Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Physician-Related Services

Billing Instructions

November 2001

Copyright Disclosure

About this publication

This publication supersedes all previous MAA RBRVS Billing Instructions.

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Washington State Department of Social and Health Services
November 2001

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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A provider may use MAA's toll-free lines for questions regarding MAA programs, however MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)]

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Other Important Numbers

Client Assistance/ Brokered Transportation Hotline (Clients Only)	1-800 562-3022
Disability Insurance	1-800-562-6074
Durable Medical Equipment (DME)/Prosthetics Authorization	1-800-292-8064
Fraud Hotline	1-800-562-6906
Healthy Options Enrollment	1-800-562-3022
PM&R Authorization	1-800-634-1398
Pharmacy Authorization **(Providers Only)**	1-800-848-2842
Provider Inquiry Hotline **(Providers Only)**	1-800-562-6188
Provider Enrollment	1-866-545-0544
Telecommunications Device For The Deaf (TDD)	1-800-848-5429
Third-Party Resource Hotline	1-800-562-6136
Ambulance Transportation/Hospice Authorization	1-800-624-4793
TAKE CHARGE	1-800-770-4334

Provider Field Representatives

(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

MAA Billing Instructions

Access to Baby & Child Dentistry
Acute Physical Medicine & Rehabilitation
Adult Day Health
Ambulatory Surgery Center
Births in Birthing Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Chiropractic Services
Community Aids Service Alternatives
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Direct Entry
Family Planning
Federally Qualified Health Centers
Fluoride Varnish Supplements
General Information Booklet
Ground/Air Ambulance Medical Transportation
EPSDT
Healthy Options Registered Health Carriers
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Hospice
Hospital-Based Inpatient Detoxification
Hospital Inpatient
Hospital Outpatient
Indian Health Services
Infusion/Parenteral Therapy
Interpreter Services
Involuntary Treatment Act (I.T.A.) Transp.
Kidney Centers
Maternity Case Management
Maternity Support Services
Medical Nutrition
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Equipment & Supplies
Nurse Delegation
Nursing Facilities
Occupational Therapy
Oxygen/Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing Services
Prosthetic & Orthotic Devices
Psychologist
Registered Nurse First Assistant (For Cesarean Sections)
Rural Health Clinics
School Medical Services
Speech/Audiology Program
TAKE CHARGE
Vision Services
Wheelchairs/Durable Medical Equipment & Supplies

For more information on MAA billing instructions, call 1-800-562-6188.

As these billing instructions are updated, they will be loaded onto our website: http://maa.dshs.wa.gov**, Billing Instructions link.**

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Definitions

The section defines terms and acronyms used in these billing instructions.

Acquisition Cost - The cost of an item excluding shipping, handling, and any applicable taxes. [WAC 388-531-0050]

Acute Care – Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).
[WAC 388-531-0050]

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.
[Refer to WAC 388-531-0050]

Admitting Diagnosis - The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment - A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions justifying the need for the equipment or the level of service being requested.

Base anesthesia units (BAU) – A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist. [WAC 388-531-0050]

Bundled services – Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.
[WAC 388-531-0050]

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.
[WAC 388-531-0050]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Covered service – A service that is within the scope of the eligible client's medical care program, subject to the limitations in WAC 388-531 and other published WAC. [Refer to WAC 388-531-0050]

Current Procedural Terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and puslied annually by the American Medical Association. [WAC 388-531-0050]

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) - Formerly known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons younger than 21 years of age who are eligible for Medicaid or the children's health program. [Refer to WAC 388-500-0005]

EPSDT Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the *EPSDT* screening.

Emergency Services - Services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the client's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited Prior Authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Fee-for-service – The general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's Healthy Options program or Children's Health Insurance Program (CHIP) programs. [WAC 388-531-0050]

Informed Consent – That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:
(1) Disclosed and discussed the client's diagnosis; and
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
(3) Given the client a copy of the consent form; and
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
(5) Given the client oral information about all of the following:
   (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
   (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
   (c) The procedure itself, including potential risks, benefits, and consequences.

[WAC 388-531-0050]

Inpatient Hospital Admission – An acute hospital stay for longer than 24 hours when the medical care records shows the need for inpatient care beyond 24 hours. All admissions are considered inpatient hospital admissions, and are paid as such, regardless of the length of stay, in the following circumstances:

(1) The death of a client;
(2) Obstetrical delivery;
(3) Initial care of a newborn; or
(4) Transfer to another acute care facility.

[WAC 388-531-0050]

Limitation Extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-531-0050]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable Fee - The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment. [WAC 388-531-0050]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Consultant - Physicians employed by MAA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, MAA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of MAA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, MAA policy, and community standards of medical care.
- Serve as advisors to MAA staff, helping them relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between MAA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for MAA at fair hearings.

Medical Identification Card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Operations, Division of (DMO) – Formerly known as DHSQS - The division within MAA responsible for promoting and improving the quality of health care consistent with community practice standards and including access, cost effectiveness, coordination and accountability to produce positive client outcomes.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Newborn – To assist providers in billing CPT codes with "newborn" in the description, MAA defines newborns as younger than 1 year of age.

Noncovered Service or Charge – A service or charge not reimbursed by the department.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Pound Indicator (#) – A symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not covered.

Prior Authorization – Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Professional Component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill. [WAC 388-531-0050]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Health Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Relative Value Unit (RVU) - A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components - physician work, practice cost, and malpractice expense.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved. [WAC 388-531-0050]

RBRVS Maximum Allowable Amount - The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised Code of Washington (RCW) - Washington State laws.

State Unique Procedure Code(s) – Procedure codes established by the Reimbursement Steering Committee (RSC) to define services or procedures not continued in CPT or HCPCS level II. [WAC 388-531-0050]

Technical Component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time. [WAC 388-531-0050]

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Introduction

Procedure Codes

The following types of procedure codes are used within this Physician-Related Services Billing Instruction:

- Physicians' Current Procedural Terminology (CPT™);
- Level II Health Care Financing Administration's Common Procedure Coding System (HCPCS); and
- State-Unique (Level III).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all MAA-covered services. **Due to copyright restrictions, MAA publishes only short CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

MAA specifies in this billing instruction:

- When MAA's guidelines differ from CPT; and
- When state-unique codes are appropriate and what the descriptions are.

Note: MAA adopts Medicare's guidelines and policies whenever possible.

Diagnosis Codes

MAA uses ICD-9-CM codes for physician related services. Providers are required to use the code of the highest specificity (5 digit codes) from the ICD-9-CM whenever possible and accurate.

MAA does not cover the following diagnosis codes:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

MAA reimburses providers for only those procedure codes and diagnosis codes that are within their scope of practice.

Noncovered Services

Procedures that are noncovered are noted with a # indicator in the Maximum Allowable column on the fee schedule.

If a client has extenuating medical circumstances not covered under the client's MAA program that the medical provider feels MAA should take into consideration for coverage, the provider must submit a written request to MAA for an Exception to Rule (ETR). A sample form is located on page I3. You may use the form or atleast submit equivalent information to MAA at the address listed below.

Send your written requests to:

ATTN: Medical Request Coordinator
Medical Operations, Medical Assistance Administration
PO Box 45506
Olympia WA 98504-5506

The following are examples of administrative costs and/or services not covered by MAA:

- Missed or canceled appointments;
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills; and
- Other areas as specified in this fee schedule.

MAA does not reimburse for services performed by any the following practitioners [WAC 388-531-0250(2)]**:**

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.) except those employed by an FQHC; or
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or
- Any other licensed practitioners providing services which the practitioner is not:
  (i) Licensed to provide; and
  (ii) Trained to provide.

Clients Enrolled in Managed Health Care

Many MAA clients are enrolled in a managed care program called Healthy Options. These clients have an HMO identifier in the HMO column on their DSHS Medical ID card. They will also receive an ID card from the managed care plan with whom they are enrolled. Clients enrolled in Healthy Options must obtain most of their services from their designated plans.

Note: Client's enrollment can change monthly. Prior to serving a Healthy Options client, make sure you received approval from <u>both</u> the plan and the client's PCP, if necessary.

Send claims to the client's managed care plan for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in the <u>General Information Booklet</u> and WAC 388-87-010.

By Report (BR)

MAA may require a special report for certain services provided to MAA clients to determine whether the procedure is indeed necessary. These services are identified by a **BR** (By Report) in the procedure code listings in this manual. This special report must include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary for the procedure or service. You may also be required to provide additional information.

Conversion Factors

These conversion factors multiplied by the Relative Value Units (RVUs) establish the rates in this fee schedule.

	7/1/95	7/1/96	7/1/97	7/1/98	7/1/99	7/1/00	7/1/01
Maternity	$44.17	$45.07	$43.34	$43.19	$44.20	$45.33	$45.34
Anesthesia	$12.41	$12.63	$12.75	$12.75	$12.96	$15.10	$15.49
Children's Primary Health Care	$43.19	$43.60	$40.77	$39.11	$37.49	$35.89	$36.52
Adult Primary Health Care	$26.13	$27.33	$24.86	$23.67	$22.47	$21.17	$21.27
All Other Procedure Codes	$22.05	$23.04	$22.25	$22.27	$21.93	$22.37	$22.41
Clinical Lab Multiplication Factor				.667	.689	.694	.720

Programs (Guidelines/Limitations)

Office and Other Outpatient Services

[Refer to WAC 388-531-0950]

In addition to those services listed in the fee schedule, the following limitations apply:

MAA reimburses for:

- One office or other outpatient call per noninstitutionalized client, per day for an individual physician (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately. See Section K.

  Example: Ventilation management (CPT codes 94656, 94657, 94660, and 94662) is not reimbursed separately **when billed in addition to** an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

  ✓ Bill the appropriate level of E&M *history and physical* (H&P) **procedures prior to performing** dental surgery in an outpatient setting. For Healthy Options clients, bill H&P claims to MAA as fee-for-service and use the appropriate ICD-9-CM dental diagnosis code.

- Two physician calls per month for a client residing in a nursing facility or an intermediate care facility.

- One physical examination per client, per year for Division of Developmental Disability clients only. See state-unique procedure code 0310M, page J109.

Children's Primary Health Care (CPT codes 99201-99215)

- MAA pays a higher reimbursement rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that will be reimbursed at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in *field 19* on the HCFA-1500 claim form. **In addition, you must add modifier 1C only to CPT codes 99201-99215**, in order for the service to be reimbursed at the higher fee. Newborns born to managed care mothers are covered by the managed care plan.

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239)
[Refer to WAC 388-531-0750]

MAA will reimburse:

- One inpatient hospital call per client, per day for the same or related diagnosis. If the call is included in the global surgery reimbursement, MAA does not reimburse separately. (See the Surgical Services Section, page F10 for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the follow-up period **only if** they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

  Note: CPT codes 99221-99223 are not payable for scheduled hospital admissions during the follow-up period without a modifier 24.

- A hospital admission (CPT codes 99221-99223) billed by a psychiatrist in combination with one of the following:

  ✓ A psychiatric diagnostic or evaluative interview examination (90801); or
  ✓ For children 20 years of age and younger, an interactive psychiatric diagnostic interview exam (CPT code 90802).

MAA will not reimburse:

- A hospital admission (CPT codes 99221-99223) **and** a planned surgery when billed in combination. The hospital admission is already included in the global fee for surgery.

- For a physician to appropriately report CPT codes 99234 through 99236 the patient must be an inpatient or an observation care patient for a minimum of 8 hours on the same calendar date.

Other Guidelines:

- When the patient is admitted to observation status for less than 8 hours and is discharged on the same date, the physician must use CPT codes 99218 through 99220 and no discharge code must be reported.

- When patients are admitted for observation care and are discharged on a different calendar date, the physician must use CPT codes 99218 through 99220 and CPT observation discharge code 99217.

- When patients qualify as an inpatient hospital admission and are discharged on a different calendar date, the physician must use CPT codes 99221 through 99233 and CPT hospital discharge day management code 99238 or 99239.

- When patients qualify as an inpatient hospital admission and discharge on the same calendar date, CPT codes 99221 through 99223 must be used for the admission service, and the hospital discharge day management service must not be billed.

- The physician must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care to bill CPT codes 99234, 99235, or 99236. The length of time for observation care or treatment status must also be documented.

Emergency Physician-Related Services **(CPT codes 99281-99285)**

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill MAA using CPT codes 99281 through 99285.

  Note: For multiple emergency room (ER) calls on the same day, with related diagnoses, you **must** indicate the time(s) of the additional call(s) on the claim form. MAA does not reimburse multiple ER calls on the same day, for the same client, with the same condition or diagnosis.

- MAA does not reimburse emergency room physicians for hospital admission charges (e.g., CPT codes 99221-99223) or additional service charges (e.g., CPT codes 99050, 99052, or 99054).

- Physicians who perform emergency room services must bill MAA for surgical procedures without modifier 54.

- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

End-Stage Renal Disease (ESRD)

(CPT codes 90935, 90937, 90945, and 90947)

- Reimbursement is limited to one dialysis procedure code per day.

- Payment for dialysis (CPT codes 90935, 90937, 90945, and 90947) includes reimbursement for the following Evaluation and Management (E&M) services performed on the same day:

  ✓ CPT codes 99231-99233; and
  ✓ CPT codes 99261-99263.

- Separate reimbursement is allowed for the following procedure codes when they are provided on the same date of service as an inpatient dialysis service (CPT codes 90935, 90937, 90945, and 90947):

  ✓ Initial hospital visit (CPT codes 99221-99223);
  ✓ Initial inpatient consultation (CPT codes 99251-99255); and
  ✓ Hospital discharge service (CPT code 99238).

- If E&M service is unrelated to dialysis procedure, bill E&M service with the unrelated diagnosis and modifier 25.

Critical Care (CPT 99291 and 99292)

[Refer to WAC 388-531-0450]

Critical care is performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

Critical care includes:

- The care of critically ill clients in a variety of medical emergencies that require the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and critically ill neonate);

- Cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergencies.

  Note: Surgery, stand-by, or lengthy consultation on a stable client does not qualify as critical care.

MAA will reimburse:

- A maximum of 3 hours of critical care per client, per day.

- The attending physician(s) for inpatient critical care who assume(s) responsibility for the care of a client during a life-threatening episode.

- More than one physician if the services provided involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following are the services (with their corresponding CPT codes) that are included in reporting critical care. Do not bill these separately:

- The interpretation of cardiac output measurements (93561-93562)
- Chest x-rays (71010, 71015, and 71020)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090)
- Gastric intubation (43752 and 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94656-94657, and 94660-94662)
- Vascular access procedures (36000, 36410, and 36600)
- Blood draw for specimen (36415 and 36540)
- Pulse oximetry (94760-94762)

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

MAA reimburses physician standby services (CPT code 99360) when:

- Used to report physician standby services requested by another physician and involving prolonged physician attendance without direct (face-to-face) patient contact.

  Note: The standby physician cannot provide care or service to other patients during this period.

- Used to report the total duration of time spent. Standby service of less than 30 minutes is not reimbursed under any circumstances.

  Note: Subsequent periods of physician standby, after the first 30 minutes, are reimbursable only when a full 30 minutes of standby is provided for each unit billed. Round down all fractions of a 30-minute time unit.

Physician standby services (CPT code 99360) are not reimbursed when:

- The period of standby ends with the performance of a procedure subject to a "global surgical reimbursement" by the physician who was on standby. Refer to page F10.

- Billed in addition to any other procedure code, with the exception of CPT codes 99431 and 99440, or when it results in an admission to a neonatal intensive care unit (CPT 99295) on the same day.

- Standby service of less than 30 minutes.

Prolonged Services (CPT codes 99354-99357)

[Refer to WAC 388-531-1350]

MAA reimburses for prolonged services:

- Up to three hours per client, per diagnosis, per day.

  Note: The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the physician and the patient (whether the service was continuous or not).

- Only when the physician provides and bills one of the procedure codes listed below for the client on the **same day** and on the **same claim**:

Prolonged CPT Code	Other CPT Code(s) Required on Same Day, Same Claim
99354	99201-99215, 99241-99245, 99301-99350
99355	99354 *and* one of the E&M codes required for 99354
99356	99221-99233, 99251-99255, 99261-99263
99357	99356 *and* one of the E&M codes required for 99356

Osteopathic Manipulative Therapy (CPT codes 98925-98929)

[Refer to WAC 388-531-1050]

MAA will reimburse:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.

  Note: Under the CPT codes, **body regions** are defined as:

  - head
  - cervical
  - thoracic
  - lumbar
  - sacral
  - pelvic
  - lower extremities
  - upper extremities
  - rib cage
  - abdomen
  - viscera

  These codes ascend in value to accommodate the additional body regions involved. Therefore, only **one code is payable per treatment**.
  For example, if three body regions were manipulated, one unit of CPT code 98926 would be payable.

- An E&M service will be reimbursed in addition to the OMT under one of the following three circumstances:

  - ✓ When a physician diagnoses the condition requiring manipulative therapy and provides the therapy during the same visit;
  - ✓ When the existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those considered included in the manipulation codes; or
  - ✓ When the physician treats the patient for a condition unrelated to the condition requiring manipulative therapy during the same encounter.

  To be reimbursed for the E&M service, use modifier 25 if the E&M service meets one of the above circumstances. Justification for the E&M and OMT service must be documented and retained in the provider's office for review.

MAA does <u>not reimburse</u>:

- Physical therapy services performed by osteopathic physicians.

Newborn Care (CPT codes 99431-99440)

To assist providers in billing CPT codes with "newborn" in the description, MAA defines newborns as younger than one year of age.

MAA will reimburse:

- **Newborn evaluations:** (CPT codes 99431-99433)
  Note: 99432 is payable only for Home Births.
  Note: Use 99435 only for newborns evaluated and discharged on the same date.

- **Discharge services:**
  Newborn admitted and discharge with different dates (CPT code 99238);
  Newborn admitted and discharged with same date (CPT code 99435).

- **Inpatient visits** (other than initial evaluation or discharge)
  (CPT codes 99218-99223).

☞ **Note: Circumcisions** (CPT code 54150 and 54160) only with medical diagnosis codes 605-Phimosis, 607.1-Balanoposthitis or 607.81-Balanitis Xerotica.

Neonatal Intensive Care Unit (NICU) (CPT codes 99295-99297)

[Refer to WAC 388-531-0900]

NICU care includes management, monitoring, and treatment of the neonate including nutritional, metabolic, and hematologic maintenance; parent counseling; and personal direct supervision by the health care team of cognitive and procedural activities.

NICU procedure codes are also included as part of the global descriptors (refer to your CPT manual).

MAA will reimburse for:

- One NICU service per client, per day.

- NICU (CPT codes 99295-99297) when directing the care of a neonate or infant in a NICU. These codes represent care beginning with the date of admission to the NICU.

  Note: Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 must be used.

- NICU procedure codes in addition to prolonged services (CPT codes 99354, 99356) and newborn resuscitation (CPT code 99440) **when the physician is present at the delivery.**

The following are the services (with their corresponding CPT codes) that are included in reporting neonatal critical care. Do not bill these separately:

- The interpretation of cardiac output measurements (93561-93562)
- Chest x-rays (71010, 71015, and 71020)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090)
- Gastric intubation (43752 and 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94656-94657, and 94660-94662)
- Vascular access procedures (36000, 36410, and 36600)
- Blood draw for specimen (36415 and 36540)
- Pulse oximetry (94760-94762)
- Umbilical venous (36510)
- Umbilial arterial (36620) catheters
- Central (36488 and 36490) or peripheral vessel catheterization (36000)
- Other arterial catheters (36140 and 36620)
- Oral or nasogastric tube placement
- Endotracheal intubation (31500)
- Lumbar puncture (62270)
- Suprapubic bladder aspiration (51000)
- Bladder catheterization (53670)
- Initiation and management of mechanical ventilation (94656 and 94657)
- Continuous positive airway pressure (CPAP) (94660)
- Surfactant administration, intravascular fluid administration, transfusion of blood components (36430 and 36440)
- Vascular punctures (36420 and 36600)
- Invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762)

Physician Care Plan Oversight **(CPT codes 99375, 99378, and 99380)**

[Refer to WAC 388-531-1150]

MAA reimburses:

- Physician care plan oversight services once per client, per month.

  ✓ A plan of care must be established by the home health agency, hospice, or nursing facility;
  ✓ The physician must provide 30 or more minutes each calendar month of oversight to the client;

  Note: For physician care plan oversight in a home health agency, hospice and nursing facility, use CPT codes 99375, 99378 and 99380.

MAA does not reimburse:

- Bundled CPT codes 99374, 99377, and 99379.
- For more than one physician during the global surgery reimbursement period unless the care plan oversight is unrelated to the surgery.

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients **20 years of age and younger** in order to identify physical and/or mental defects. If a physical or mental defect is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

MAA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health; and
- Registered nurses working under the guidance of a physician or ARNP may also do EPSDT screenings. However, only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

Who is eligible for EPSDT screenings?

MAA reimburses EPSDT screenings for clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP - Children's Health	CNP - Children's Health Program
CNP – CHIP	CNP - Children's Health Insurance Program
CNP – Emergency Medical Only	CNP – Emergency Medical Only *(Covered only when the service is related to the emergent condition.)*
LCP-MNP	Limited Casualty Program – Medically Needy Program

☞ **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in a Healthy Options managed care plan eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service under the Healthy Options managed care program. Clients who are enrolled in one of MAA's Healthy Options managed care plans will have an identifier in the HMO column on their DSHS Medical ID card.

Please refer Healthy Options managed care clients to their respective health care plan for necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill MAA for EPSDT services as they are included in the Healthy Options managed health care plan's reimbursement rate.

Primary Care Case Manager/Management (PCCM):

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM.

> ☞ **Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

As a minimum, EPSDT screenings must include, but are not limited to:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive, **unclothed** physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
  - ✓ How to clean teeth as they erupt.
  - ✓ How to prevent baby bottle tooth decay.
  - ✓ How to look for dental disease.
  - ✓ Information on how dental disease is contracted.
  - ✓ Preventive sealant.
  - ✓ Application of fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

These components may be performed separately by licensed providers; however, MAA encourages the primary care provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components:

The following screening component services may be billed in addition to the screening codes for fee-for-service clients by using procedure codes published in these billing instructions.

- ✓ Appropriate audiometric tests (CPT codes 92552 and 92553);
- ✓ Appropriate laboratory tests, including testing for anemia;
- ✓ Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

1. Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

   - 1st Screening: Birth to 6 weeks old
   - 2nd Screening: 2 to 3 months old
   - 3rd Screening: 4 to 5 months old
   - 4th Screening: 6 to 7 months old
   - 5th Screening: 9 to 11 months old

2. Three screening examinations are required between the ages of 1 and 2 years.
3. One screening examination is required per 12-month period for children ages 2 through 6.
4. One screening examination is required per 24-month period for children age 7 through 20, except foster care clients, who receive a screening examination every 12 months.

Foster Care Children (As published in Numbered Memorandum 01-64 MAA)

Effective for claims with dates of service on and after November 1, 2001, through June 30, 2003, MAA will reimburse providers an enhanced flat fee of $120.00 per EPSDT screen for foster care children who receive their medical services through MAA's fee-for-service system. This applies to CPT™ codes 99381-99385 and 99391-99395 only.

To receive the enhanced rate, providers **must** include modifier 21 in field 24D on the HCFA-1500 claim form to identify the child as a foster care child.

> **Foster care is defined as:**
> *Twenty-four hour per day temporary substitute care for a child placed away from the child's parents or guardians in licensed, paid, out-of-home care and for whom the department [DSHS] or a licensed or certified child placing agency has placement and care responsibility…*

To receive the enhanced rate, providers are required to use either:

- The new DSHS "Well Child Exam" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)]; **or**
- Another charting tool with equivalent information.

The Well Child Exam forms are available from the DSHS Warehouse at no cost and may be used for all children. After completion, these forms must be retained in the client's file.

To request copies of the Well Child Exam forms, write or fax:

DSHS Warehouse
PO Box 45816
Olympia, WA 98504-5816
FAX: (360) 664-0597
Or Download from the Internet:
http://www.wa.gov/dshs/dshsforms/forms/eforms.html

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
Managed Care plans or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	Within 21 days of request
	Children – two years and older.	Within six weeks of request.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	0 through 20 years of age	Within 14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

What are EPSDT interperiodic screenings? (state-unique procedure code 0252M)

An EPSDT interperiodic screening (or "*interim screening*") is a modified or limited screening performed when a health problem is suspected, but the client has already received the maximum number of screening(s) for the year.

Physicians and ARNPs can bill, using a separate HCFA-1500 claim form, an evaluation and management procedure code (CPT codes 99201-99215) for clients (excluding managed care clients) who are found to have a medical problem. Use the ICD-9-CM diagnosis code that most accurately describes the client's condition. If no medical problem is found, bill MAA using state-unique procedure code 0252M.

For clients not enrolled in a managed care plan, when an immunization(s) is the only EPSDT service performed, an interperiodic screening may be billed in addition to the immunization.

What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Provide the service for the client (if it is within the provider's scope of practice); or
- Refer the client to an appropriate provider for medical treatment.

Referrals

Chiropractic Services
Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services
Eligible clients may go to a dental provider without an EPSDT screen or referral. You should inform the client or the client's parent(s) or guardian(s) of the importance of oral/dental health and recommend that the client be seen by a dentist yearly, or sooner if a problem is suspected.

Note: Unless a problem is suspected earlier, the child should be at least 1 year of age and have his/her first tooth.

Orthodontics
Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA reimburses orthodontics for children with cleft lip or palates or severe handicapping maloclussions only. You must obtain prior authorization from MAA before providing orthodontic services. MAA does not reimburse orthodontic treatment for other conditions.

Lead Toxicity Screening
Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgement when screening for lead toxicity.

Fetal Alcohol Syndrome (FAS) Screening
FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen every child six months of age and older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children for whom there is known in utero exposure and for whom there is suspicion of facial characteristics of FAS and/or microcephaly can be referred to a diagnostic clinic.

Medical Nutrition Therapy

(formerly known as "Nutritional Counseling")

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

MAA covers the procedure codes listed below when referred by an EPSDT provider.

☞ **Note:** Medical nutrition therapy is a face-to-face interaction between the certified dietitian and a client and/or caregiver. MAA limits initial assessments to 2 hours (or 8 units) per year and reassessments to no more than 1 hour (or 4 units) per day. MAA limits group therapy to 1 hour (or 2 units) per day. MAA reimburses for medical nutrition therapy only when referred by an EPSDT provider.

Effective for claims with dates of service on or after July 1, 2001, MAA has discontinued state-unique procedure codes 0910M and 0911M and has replaced them with CPT procedure codes 97802 and 97803.

Due to copyright restrictions, MAA publishes only the short CPT descriptions.
To view the entire description of each code, please refer to your current CPT manual.

Discontinued State-Unique Code	CPT™ Procedure Code	Short Description	7/1/01 Maximum Allowable Fee
0910M	97802	Medical nutrition therapy, individual, initial 1 unit=15 minutes	$11.49 per unit Max. of 2 hours (8 units) per year
0911M	97803	Medical nutrition therapy, individual, subsequent 1 unit=15 minutes	$11.49 per unit Max. of 1 hour (4 units) per day
N/A	97804	Medical nutrition therapy, group 1 unit=30 minutes	$11.49 per unit Max. of 1 hour (2 units) per day

Fluoride Varnish (Physicians and ARNPs)

(State-unique code 0122D)

In cooperation with the University of Washington's School of Dentistry, the Medical Assistance Administration's (MAA) goal is to improve the oral health of Medicaid-eligible clients, 18 years of age and younger, through the application of fluoride varnish.

In order to achieve this goal effectively, a protocol has been developed for physicians, advanced registered nurse practitioners, and nurses to apply fluoride varnish to the teeth of Medicaid-eligible children.

What is fluoride varnish? How often is it applied?

Fluoride varnish is a type of topical fluoride that acts to retard, arrest and reverse the caries process. It is applied up to three times per year to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

These fluoride varnish applications are viewed as preventive in nature and are not intended to replace routine dental care by a dentist.

Who must order the fluoride varnish?

- Dentists;
- Physicians; or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. DDD clients age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in a Healthy Options managed health care plan. These clients **are eligible for fluoride varnish applications** through fee-for-service. Fluoride varnish applications must be billed directly to MAA for reimbursement.

Immunizations – Children

(This applies to clients 20 years of age and younger. For clients 21 years of age and older refer to the Immunizations-Adults on page C12.)

Immunizations for EPSDT are usually given in conjunction with a screening or interperiodic screening. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis from the immunization.

- MAA reimburses an administration fee (up to $5.00) for vaccines available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and younger. When you receive immunization materials received from the Department of Health, you must bill the appropriate procedure code with modifier 1H (e.g., 90700-1H). **In the following list, the procedure codes that are shaded identify these vaccines. Do not bill CPT codes 90471 and 90472.**

- Reimbursement rates for immunization materials include federal excise tax. Do not bill with modifier 1H for any of the following procedure codes if the client is 19 through 20 years of age, or if the procedure code is NOT shaded. In addition, bill 90471 and 90472 with the vaccine or toxoid procedure code.

  Do not bill administration codes 90471 and 90472 as multiple units or more than once per day, per client.

- Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. Bill only CPT code 90471 when administering one vaccine. MAA reimburses up to a maximum of $8.00 when CPT code 90471 and 90472 are billed in combination.

- When an immunization is the only service performed, an interperiodic screen (0252M) may be billed.

- For all providers **except Health Departments**, MAA adopts CPT guidelines regarding billing E&M procedures with immunizations. The only time that an E&M procedure can be billed with an immunization is if there is a separate, identifiable diagnosis. If a Health Department gives the immunization and it is the only service performed, continue to bill E&M CPT code 99211.

Pneumococcal Vaccine

Pneumococcal vaccine PCV7 (CPT code 90669) - Formerly known as Prevnar, this vaccine is available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program, and distributed through the Department of Health (DOH).

Effective for dates of service on or after May 1, 2001, MAA no longer reimburses for CPT code 90669 without modifier 1H. MAA reimburses an administration fee (up to $5.00) for DOH-supplied vaccines. Vaccines obtained from DOH must be billed using the appropriate procedure code with modifier 1H (e.g. 90669-1H).

When immunization materials for PCV7 are obtained from DOH, prior authorization is not required from MAA.

Due to copyright restrictions, MAA publishes only short CPT descriptions.
To view the full CPT description, please refer to your current CPT manual.

CPT	Immunization
90585	Bcg vaccine, percut
90586	Bcg vaccine, intravesical
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90659	Flu vaccine, whole, im
90665	Lyme disease vaccine, im
90669	Pneumococcal vacc, ped<5
90675	Rabies vaccine, im
90676	Rabies vaccine, id
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90700	Dtap vaccine, im
90701	Dtp vaccine, im
90702	Dt vaccine <7, im
90703	Tetanus vaccine, im
90704	Mumps vaccine, sc
90705	Measles vaccine, sc
90706	Rubella vaccine, sc
90707	Mmr vaccine, sc
90708	Measles-rubella vaccine, sc
90709	Rubella & mumpsvaccine, sc
90712	Oral poliovirus vaccine
90713	Poliovirus, ipv, sc
90716	Chicken pox vaccine, sc
90717	Yellow fever vaccine, sc
90718	Td vaccine >7, im
90720	Dtp/hib vaccine, im
90725	Cholera vaccine, injectable
90732	Pneumococcal vacc, adult/ill
90733	Meningococcal vaccine, sc
90735	Encephalitis vaccine, sc
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hepb vacc ped/adol 3 dose, im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose, im
90748	Hep b/hib vaccine, im
90749	Vaccine toxoid

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger refer to the Immunizations-Children Section, page C9.)

Immunization materials are reimbursed at MAA's established Maximum Allowable Fee (MAF). Bill administration CPT codes 90471 and 90472 in addition to the immunization materials.

Do not bill an E&M procedure with an administration unless there is a separate identifiable diagnosis.

Do not bill administration codes 90471 and 90472:

- ✓ As multiple units; or
- ✓ More than once each, per day, per client.

Bill both CPT code 90471 and 90472 with one unit per code when administering more than one vaccine. Bill only CPT code 90471 when administering one vaccine. MAA reimburses up to a maximum of $8.00 when CPT codes 90471 and 90472 are billed in combination.

Due to copyright restrictions, MAA publishes only short CPT descriptions. To view the full CPT description, please refer to your current CPT manual.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, percut	90705	Measles vaccine, sc
90586	Bcg vaccine, intravesical	90706	Rubella vaccine, sc
90632	Hep a vaccine, adult im	90707	Mmr vaccine, sc
90636	Hep a/hep b vacc, adult im	90708	Measles-rubella vaccine, sc
90645	Hib vaccine, hboc, im	90709	Rubella & mumpsvaccine, sc
90646	Hib vaccine, prp-d, im	90712	Oral poliovirus vaccine
90647	Hib vaccine, prp-omp, im	90713	Poliovirus, ipv, sc
90648	Hib vaccine, prp-t, im	90716	Chicken pox vaccine, sc
90658	Flu vaccine, 3 yrs, im	90717	Yellow fever vaccine, sc
90659	Flu vaccine, whole, im	90718	Td vaccine >7, im
90665	Lyme disease vaccine, im	90720	Dtp/hib vaccine, im
90675	Rabies vaccine, im	90725	Cholera vaccine, injectable
90676	Rabies vaccine, id	90732	Pneumococcal vacc, adult/ill
90690	Typhoid vaccine, oral	90733	Meningococcal vaccine, sc
90691	Typhoid vaccine, im	90735	Encephalitis vaccine, sc
90692	Typhoid vaccine, h-p, sc/id	90740	Hepb vacc, ill pat 3 dose, im
90700	Dtap vaccine, im	90746	Hep b vaccine, adult, im
90701	Dtp vaccine, im	90747	Hepb vacc, ill pat 4 dose, im
90703	Tetanus vaccine, im	90748	Hep b/hib vaccine, im
90704	Mumps vaccine, sc	90749	Vaccine toxoid

Immune Globulins

- **RespiGam -** Bill HCPCS code J1565 for Respigam only.

- **Synagis (CPT code 90378)** - MAA covers this immune globulin only after prior authorization has been obtained. The following payment levels have been established for Synagis:

Description	Maximum Allowable Fee
Synagis, 50 mg	$598.00
Synagis, 100 mg	$1,128.00
Synagis, 150 mg	$1,726.00
Synagis, 200 mg	$2,256.00

Requests for authorization must be submitted in writing to:

MAA-Medical Operations-QFFS
Synagis Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

- ✓ Bill one unit for each 50 mg used.
- ✓ Bill using CPT code 90399 through dates of service 12/31/99.
- ✓ **Effective with dates of service on and after January 1, 2000, bill using CPT code 90378.**

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1 ml syringes used. Bill each 1 ml syringe used as 1 unit.

- **Immune Globulins** - CPT codes 90287, 90288, 90296 and 90393 are not covered if the provider obtained the immune globulins at no cost from either the Center for Disease Control or California Department of Health. MAA reimburses the provider for the administration of the immune globulin using CPT codes 90782-90784.

  For CPT code 90396 (varicella-zoster immune globulin), each one unit billed equals one 125 unit vial, with a maximum reimbursement of five vials per session.

CPT codes 90281, 90283, 90291, 90379, 90384, 90385, 90386, and 90389 are not covered. (Use the appropriate J codes listed in the following table.)

However, the corresponding HCPCS codes are reimbursed by MAA at acquisition cost:

Non-Covered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1561, J1563
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670

- ## Rabies Immune Globulin (RIG) (CPT codes 90375-90376)

✓ RIG is reimbursed at acquisition cost.

✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

✓ RIG is sold in either 2 ml or 10 ml vials.
✓ One dose is allowed per episode.
✓ Bill one unit for each 2 ml vial used per episode.

For example:
- ➢ If a patient weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
- ➢ If a patient weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

Therapeutic or Diagnostic Injections
(CPT codes 90782-90784, 90788, 90799)

[Refer to WAC 388-531-0950]

- MAA reimburses physicians for injection procedures and/or injectable drug products provided to a client in the following circumstance only:

  ✓ When the injectable drug used is from office stock purchased by the physician from a pharmacist or drug manufacturer.

- If no other service is performed on the same day, subcutaneous or intra-muscular (CPT code 90782) or intra-muscular antibiotic (90788) can be billed in addition to a J or Q procedure code.

- When a subcutaneous or intra-muscular injection (CPT code 90782) or an intra-muscular antibiotic injection (CPT code 90788) is provided on the same day as an Evaluation & Management (E&M) service, the injections are bundled into the E&M service.

- Intra-arterial (CPT code 90783) and intravenous therapeutic or diagnostic (90784) injections are reimbursed separately even when provided on the same day as an E&M service. Separate payment for the drug is allowed. Use the appropriate J or Q code. However, these injections are <u>not</u> reimbursed separately if provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781).

  Note: Drugs must be billed using the HCPCS J & Q codes and reimbursed at cost. Name, strength, and dosage of the drug must be documented and retained in the client's file for review. For billing and reimbursement of chemotherapy services, see page F7.

Hyalgan/Synvisc

- Only orthopedic surgeons and rheumatologists are reimbursed for Hyalgan or Synvisc.
- A maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee are allowed. Identify left knee or right knee by adding the appropriate "LT" or "RT" modifier to your claim.
- MAA changed the pricing of Hyalgan (HCPCS code J7315) and Synvisc (HCPCS code J7320) to match the dosage within the description of the code.

HCPCS Code	Description	Maximum Allowable Fee	Restrictions
J7315	Sodium hyaluronate, 20 mg, for intra-articular injection (Hyalgan)	$132.20	Maximum of 5 Max. pymt = $661.00
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc)	$215.65	Maximum of 3 Max. pymt = $646.95

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee with the following diagnoses:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg
715.18	Osteoarthritis, localized, primary, other specified sites
715.26	Osteoarthritis, localized, secondary, lower leg
715.28	Osteoarthritis, localized, secondary, other specified sites
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg
715.38	Osteoarthritis, localized, not specified whether primary or secondary, other specified sites
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg
715.98	Osteoarthritis, unspecified whether generalized or localized, other specified sites.

- The series of injections must be billed after all injections are completed. It is billed as five (5) units for Hyalgan and three (3) units for Synvisc (per knee).
- Bill CPT code 20610 each time an injection is given, up to a maximum of 5 for Hyalgan and 3 for Synvisc.
- **You must bill both the injection CPT code and HCPCS procedure codes on the same claim form.**

Clozaril Case Coordination

- Only physicians, psychiatrists, ARNPs, and pharmacists are reimbursed.
- One Clozaril case coordination, state unique code 0857J, is allowed per week.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) (CPT code 85022) may be billed in combination when providing Clozaril case coordination.

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Vision Care Services (Includes Ophthalmological Services)

Who is eligible for vision care services?

Clients with one of the following identifiers on their DSHS Medical ID cards are eligible for vision care services:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP - Children's Health	Categorically Needy Program – Children's Health
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Medical Only *(Covered only when the service is related to the emergent condition)*
GA-U - No Out of State Care	General Assistance-Unemployable - No Out of State Care
General Assistance – No Out of State Care	ADATSA
LCP – MNP	Limited Casualty Program - Medically Needy Program
LCP-MNP Emergency Medical Only	Limited Casulty Program – Medically Needy Program *(Covered only when the service is related to the emergent condition)*
Note: Clients with **Family Planning Only** and **TAKE CHARGE** identifiers are NOT covered.	

Limited Coverage:

Office and ambulatory surgical center services are not payable when the client(s) has the following identifier on their DSHS Medical ID cards. In certain situations, a client is put on the Medically Indigent Program (MIP) for the sole purpose of cataract surgery or retinal detachment.

Medical Program Identifier	Medical Program
Emergency Hospital and Ambulance Only	Medically Indigent Program

For clients with the following identifier on their DSHS Medical ID card, MAA only pays the Medicare premiums and copay.

Medical Program Identifier	Medical Program
QMB-Medicare Only	Qualified Medicare Beneficiary **(Medicare Premiums/Copays Only)**

Are clients enrolled in a Healthy Options managed care plan eligible for vision care services?

Clients with an identifier in the HMO column on their DSHS Medical ID card are enrolled in one of MAA's managed care plans. **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's Healthy Options managed care plan. Clients can contact their plans by calling the telephone number listed on their DSHS Medical ID card.

Frames, lenses, and contact lenses must be ordered from MAA's contractor (see page D16). These items are reimbursed fee-for-service. Eligibility, coverage, and billing guidelines found in this billing instruction and MAA's Vision Care Services Billing Instruction apply to Healthy Options clients.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their DSHS Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form.

> ☞ **Note: For further information on Healthy Options, see MAA's website: http://maa.dshs.wa.gov/HealthyOptions.**

What services are covered and how often?

Eye examinations, refractions, and fitting fees

MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and lenses), and fitting fees as follows:		
Asymptomatic clients	Adults (21 years or older)	Once every 24 months
Asymptomatic clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Adults and Children	Once every 12 months

(The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.) MAA limits eyeglass reimbursement to specific contract frames and contract lenses. MAA pays a fitting fee for frames, lenses, and contact lenses provided by, or obtained through, the contractor (see page D16). If the client has a serviceable frame that meets MAA's size and style requirements, MAA will pay for a fitting fee.

Under what circumstances would the above previous limits NOT apply?

1. **Change in prescription (spherical equivalent of ±1 diopter):** The 24-month limitation does not apply to a change in prescription spherical equivalent of ±1 diopter. To justify this diopter change, you must use **state-unique diagnosis code 367.99**.

2. **Clients in nursing facilities:** MAA reimburses for services provided to clients in a nursing facility. Services must be ordered by the client's attending physician and documented in the facility's client care plan. The need for services must be clearly documented in the facility's client medical record, and the corresponding services provided must be documented in the medical record at the time the services are delivered.

3. **Eye examinations relating to medical conditions:** MAA reimburses for examinations relating to medical conditions (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.) as often as medically necessary.

4. **Eye exam due to lost or broken glasses**

   MAA covers eye exams within two years of the last exam when no medical indication exists and **both** of the following are documented in the client's record:

   - The glasses or contacts are broken or lost; and
   - The last exam was 18 months ago or longer.

   Note: Use MAA's Expedited Prior Authorization. See Section I – Authorization.

5. **Visual field exams (CPT codes 92081, 92082, and 92083)** MAA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support medical necessity for the visual field tests.

   Documentation in the record must show:

   - ✓ The extent of the testing;
   - ✓ Why the testing was reasonable and necessary for the client; and
   - ✓ The medical basis for the frequency of testing.

Program Limitations

Special Ophthalmological Services - Bilateral Indicator: MAA considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. For MAA purposes, this includes CPT code 92015, determination of refractive state**.** Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

Reporting Diagnoses: MAA requires a diagnosis for a medical condition. The diagnosis assigned to a procedure is the first-level justification for that procedure. Please note: Use V72.0 (Examination of eyes and vision) only for eye exams in which no problems were found.

E&M Procedures: Use Evaluation and Management (E&M) codes for eye examinations for a medical problem, not for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are not appropriate when billing E&M services.

What services are not covered?

MAA does not cover:

- ✓ Evaluation and Management (E&M) codes and an eye exam on the same day;
- ✓ Nursing home visits and an eye exam on the same day;
- ✓ Any services with prescriptions over two years old;
- ✓ Missed appointments;
- ✓ Orthoptics and visual training therapy; or
- ✓ Group vision screening for eyeglasses (except for EPSDT services).

Eyeglasses

When does MAA cover eyeglasses (frames and/or lenses)?

MAA covers eyeglasses (frames and/or lenses) when the:

- Client's condition that requires correction in one or both eyes is stable;
- Prescription is less than two years old; and
- Minimum correction need is documented and meets one of the following:
  - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopters; or
  - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopters.

MAA limits eyeglass reimbursement to specific contract frames, lenses, and contact lenses. MAA pays a fitting fee for **only** frames, lenses, and contact lenses provided by, or obtained through MAA's contractor (see page D16). However, if the client owns serviceable frames that meet MAA's size and style requirements, MAA pays for a fitting fee.

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required len(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage working with these frames can be unpredictable. MAA's contractor does not accept responsibility for these frames.

How often does MAA cover eyeglasses (lenses/frames)?

MAA covers eyeglasses as follows:		
Clients	Adults (21 years or older)	Once every 24 months
Clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Adults and Children	Once every 12 months
Clients who have been unable to adjust to contact lenses after 30 days.	Adults and Children	As medically necessary *(The provider must document the client's inability to adjust and the client must return the eyeglasses to the provider.)*

Replacements

MAA covers replacement eyeglasses (lenses/frames) that have been broken or lost as follows:	
Clients 21 years and older	Requires MAA's expedited prior authorization (see Section I)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization

Additional Options

Nonallergenic frames

If the client has a medically diagnosed allergy to metal, MAA covers coating the frames to make them non-allergenic.

Upgrades

MAA **does not** authorize clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations.

Back-up eyeglasses

MAA covers back-up eyeglasses when contact lenses are the client's primary visual correction aid (see Contact Lenses section, page D12) as follows:

Clients 20 years or younger	One pair every two years
Clients 21 years and older	One pair every six years

Durable or Flexible Frames

MAA covers pre-approved special frames called "durable frames and flexible frames" through MAA's contracted supplier when a client:

- Is diagnosed with a seizure disorder that results in frequent falls; or
- Has a medical history that has resulted in two or more broken eyeglass frames in a 12-month period.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

What is not covered?

MAA does **not cover** the following eyeglasses:

- ✓ Eyeglasses upgraded at private expense to avoid MAA's contract limitations;
- ✓ Two pairs of glasses in lieu of multifocals; or
- ✓ Non-medically necessary glasses.

Eyeglass Lenses

What is covered?

MAA covers the following eyeglass lenses and lens treatments:

Eyeglass Lenses and Lens Treatment (through Contractor)

1. One pair of:

- Single vision;
- Round or flat top D-style bifocals; and
- Trifocals (25 mm or 28mm);

2. **Glass Lenses** (in clear only)

In eye-size 54 millimeters or smaller for all contract frames or noncontract serviceable* frames owned by MAA clients.

***Note:**	Due to time, exposure to elements, and concealed damage, working with noncontract frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

3. Plastic Lenses (in clear only)

In all sizes to fit all contract frames or noncontract frames owned by MAA clients. Plastic lenses can be up to any prescription power. (For information on tinted lenses, see page D9.)

4. Treating Plastic Lenses for Scratch Resistance

MAA covers treating plastic lenses for scratch resistance only when the client:

- Is 20 years of age or younger; or
- Is determined by MAA to be developmentally disabled (check the client's DSHS Medical ID card for an "X" in the DD column).

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required lense(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage, working with noncontract frames frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

Which eyeglass lenses and lens treatment require medical justification?

Medical justification and/or ICD-9-CM diagnosis code(s) must be clearly written on the order form to the contractor for the following lenses:

1. Bifocal Lenses Replaced with Single Vision Lenses – or -
Trifocal Lenses Replaced with Bifocal Lenses or Single Vision Lenses

Due to a client's normal inability to adjust quickly to lens changes, MAA requires **all of the following** before allowing lenses to be replaced as specified above:

- A client must attempt to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses are returned to the provider.

A statement from the attending physician must be in the client's record indicating that the treatable condition(s) is stable before new lenses may be allowed.

2. High Index Lenses for Refractive Change

MAA covers high index lenses when the client requires a refractive correction of plus or minus 8 diopters or greater.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

3. Executive Bifocals or Trifocals (plastic only)

MAA covers plastic executive bifocals or trifocals only for clients who are diagnosed with:

- Accommodative estropia (client demonstrates that one or both eyes tend to turn in under fatigue or stress); or
- Strabismus.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process along with ICD-9-CM diagnosis codes 378.0-378.9. See Section I.**

4. Tinting of Plastic Lenses

MAA covers the tinting of plastic lenses only when:

- The client's medical need is diagnosed and documented as a chronic eye condition (expected to last longer than 3 months) causing photophobia; and
- The tinting is done by MAA's contracted lens supplier.

When billing MAA, use the appropriate ICD-9-CM code from the following list:

Medical Problems	ICD-9-CM Diagnosis Codes
Chronic iritis, iridocyclitis (uveitis)	364.10-364.11 364.51-364.59
Optic atrophy and/or optic neuritis causing photophobia	377.10-377.63
Chronic corneal keratitis	370.00-370.07
Glaucoma	365.00-365.9
Rare photo-induced epilepsy conditions	345.00-345.91
Migraine disorder	346.00-346.21
Diabetic retinopathy	362.01-362.02

5. Glass Photochromatic Lenses (includes photogray lenses)
Plastic photochromatic lenses are not allowed.

MAA covers glass photochromatic lenses only when the client's medical need is diagnosed and documented as related to either of the following:

- Ocular albinism; or
- Blindness.

Medical Problems	ICD-9-CM Diagnosis Codes
Albinism	270.2
Retinitis pigmentosa	362.74
Optic atrophy and/or optic neuritis	377.10-377.63

6. Polycarbonate Lenses

MAA covers polycarbonate lenses when a client:

- Is blind in one eye (see definition for "blind") and needs protection for the other eye, regardless of whether a vision correction is required; or
- Is 20 years of age or younger and diagnosed with strabismus or amblyopia; or
- Is identified by MAA as developmentally disabled, regardless of the client's age.

Medical Problems	ICD-9-CM Diagnosis Codes	
Persons who are blind in one eye and need protection for the other eye.	369.60-369.69 369.71-369.73	
Infants/toddlers with motor ataxia	331.89 334.0-334.9	781.2 781.3
Amblyopia	368.01-368.03	
Young children with strabismus	378.00-378.9	

Replacements

- MAA covers lens replacement for lost, broken, or stolen lenses (outside the 90-day warranty period provided by the contractor) as follows:

Clients 21 years and older	**Requires MAA's EPA Process** (see Section G)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization

- MAA covers lens replacements through the expedited prior authorization (EPA) process without regard to time limits when all of the following apply:

  - ✓ One of the following caused the vision change:
    - ➢ Eye surgery;
    - ➢ The effect(s) of prescribed medication; or
    - ➢ One or more diseases;
  - ✓ Both the eye condition and the treatment have stabilized; and
  - ✓ The lens correction has at least one diopter difference between the old and new prescriptions. (A change of at least one diopter does not apply to separate pairs of eyeglasses for distance and reading, or for two pair of eyeglasses in place of multifocals.)

What lenses are not covered?

MAA does **not cover** the following eyeglass lenses:

- ✓ High index lenses with correction less than 8 diopters;
- ✓ Second or replacement lenses during pregnancy due to unstable refractive changes;
- ✓ Plastic photochromatic lenses;
- ✓ Glass lenses of prescription power plus or minus 8 diopters;
- ✓ Varilux or other progressive addition-type multifocals, including blended bifocals; or
- ✓ Sunglasses.

Contact Lenses

How often does MAA cover contact lenses?

MAA covers contact lens replacements only once every 12 months.

What is covered?

MAA covers the following contact lenses:

1. **Gas permeable or daily wear soft contact lenses** as the client's primary refractive correction method if a client has a vision correction of plus or minus 6.0 diopters. (Use ICD-9-CM codes 367.0 or 367.1.)

2. **Therapeutic contact bandage lenses** only when needed immediately after either of the following:

   - Eye injury (ICD-9-CM codes 871.0-871.9); or
   - Eye surgery (CPT codes 65091-67599, 68020-68399).

> ☞ **Note:** MAA does not cover contact lenses if the client's ocular condition makes it inadvisable for the client to use contact lenses.

3. **Lenticular, aspheric, and myodisc contact lenses** when the client has one or more of the following:

   - Multiple cataract surgeries on the same eye;
   - Aphakia;
   - Keratoconus with refractive error of plus or minus 10 diopters; or
   - Corneal softening (e.g., bullous keratopathy).

Medical Problems	ICD-9-CM Diagnosis Codes
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Multiple cataract surgeries on the same eye (12-month limit does not apply)	366.00-366.09 366.17-366.9
Corneal softening, such as caused by Bullous Kerotopathy	371.23

4. **Soft toric contact lenses** (daily wear) for clients with astigmatism requiring a vision correction of plus or minus one diopter. They must also meet the vision requirement listed in #1. (Use ICD-9-CM codes 367.20, 367.21, or 367.22 for astigmatism.)

Replacements

MAA covers the replacement of contacts within one year of the last dispense when contacts are broken or lost and **both** of the following are documented in the client's record:

- Copy of current prescription (must not be older than 17 months); and
- Date of last dispense documented.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

What contact lenses are not covered?

- ✓ Contact lenses for a client who has received MAA-covered eyeglasses within the past 2 years, unless the provider can document the medical necessity to MAA's satisfaction;
- ✓ Disposable contact lenses; or
- ✓ Contact lenses upgraded at private expense to avoid MAA's contract limitations.

Billing for Fitting Fees

Please use the following state-unique procedure codes when billing MAA for fitting fees for contact lenses.

State-Unique Procedure Code	Description
9275M	Fitting fee including dispensing for therapeutic bandage lenses. (This includes 14-day follow-up care.)
9276M	Fitting fee including dispensing for contact lenses. (This includes 30-day follow-up care for the training period.)
9277M	Fitting fee including dispensing of contact lenses for treatment for disease. (This includes 90-day follow-up care.)

Ocular Prosthetics

When does MAA cover ocular prosthetics?

MAA covers ocular prosthetics when they are medically necessary and provided by any of the following enrolled/contracted providers:

- An Ophthalmologist;
- An Ocularist; or
- An Optometrist who specializes in orthotics.

HCPCS Procedure Codes: Please use one of the following HCPCS procedure codes when billing for Ocular Prosthesis.

HCPCS Code	Description
V2623	Prosthetic, eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2630	Anterior chamber intraocular lens
V2631	Iris, supported intraocular lens
V2632	Posterior chamber intraocular lens

Cataract Surgeries

When does MAA cover cataract surgery?

MAA covers cataract surgery when it is medically necessary and the provider clearly documents the need in the client's file.

MAA considers the surgery medically necessary when the client has either of the following:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:

  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis; or
  - ✓ Phacoanaphylactic endopthalmitis.

Strabismus Surgeries

When does MAA cover strabismus surgery?

MAA covers surgical procedures for strabismus (CPT codes 67311-67340) only for clients 17 years of age and younger.

Where and How Do I Order Eyeglasses and Contact Lenses?

Who is MAA's eyeglass contractor?

MAA's eyeglass contractor is Airway Optical (Washington State Department of Correctional Industries).

Eyeglasses and contact lenses, including therapeutic soft contact (bandage) lenses, are covered for eligible Medical Assistance clients only through Airway Optical. No other optical manufacturer or provider will be reimbursed for frames, lenses, or contact lenses.

Send or fax completed prescriptions and/or purchase orders for sample kits, eyeglass frames, lenses, and contact lenses to:

Airway Optical

11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: 1-888-606-7788
Fax: 1-888-606-7789

General Ordering Information

- **Airway Optical will supply prescription order forms upon request.**
  Please call Airway Optical's toll-free number at (888) 606-7788 or fax (888) 606-7789 to order additional forms.

- All prescriptions must be legible and include the prescribing provider's name and return address. The eyeglasses will be mailed to the provider by Airway Optical.

- Providers must mail eyeglass orders, along with a copy of the client's DSHS Medical ID card, to the contractor. Orders and DSHS Medical ID cards may also be faxed. The copy of the Medical ID card must be legible. Keep a copy of the order on file, along with the verification of the fax order.

- DSHS requires Airway Optical to process prescriptions within 10 working days, including shipping and handling time, after receipt of a properly completed order. MAA allows 20 days for completing special orders. Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery timeframes.

- Include the appropriate diagnosis code on all order forms for eyeglass and contact lenses. If the appropriate diagnosis code is not included on the form, the contractor is required to reject and return the order.

- The contractor will reject and return an order for an eligible client for whom MAA has already purchased a pair of lenses and/or complete frame within the applicable benefit period (12 or 24 months, as appropriate). Similarly, the contractor will reject an order for contact lenses for an eligible client if MAA has already paid for contact lenses or eyeglasses for that client within the past 12 months.

- To obtain general information, or to inquire about overdue prescriptions, call the contractor at their toll-free number.

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Allergen Immunotherapy

[Refer to WAC 388-531-0950(10)]

Reimbursement for antigen/antigen preparation codes (CPT codes 95145-95149, 95165 and 95170) are **per dose**.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ **One injection** (CPT code 95115 or 95117); **and** ✓ **One antigen/antigen preparation** (CPT codes 95145, 95146, 95147, 95148, 95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; or ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ Bill CPT code 95144
Allergists who billed the complete service procedures (CPT codes 95120-95134) and use treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); **and** ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

- Reimbursement for an allergist billing both an injection and either CPT code 95144 or 95165 will be the injection plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) for conditions not related to allergen immunotherapy.

Psychiatric Services

[Refer to WAC 388-531-1400]

Inpatient Hospital

- MAA covers one hospital call for direct psychiatric client care, per client, per day. Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making rounds is considered direct client care and includes any one of the following:

  - ✓ Brief (up to one hour) individual psychotherapy;
  - ✓ Family (90847)/group (90853/90857) psychotherapy;
  - ✓ Electroconvulsive therapy; or
  - ✓ Pharmacologic management.

- Clients may receive either:

  - ✓ Inpatient psychotherapy only.

    🗎**Note:** Use one of the following procedure codes when billing for only psychotherapy services: CPT code 90816, 90818, 90823, 90826, 90845, 90847, 90853, 90857, 90862, 90865, 90870, 90871, or state-unique code 9084M.

  -OR-

  - ✓ Psychotherapy <u>with</u> medical evaluation and management.

    🗎**Note:** Use one of the following procedure codes when billing psychotherapy services and medical evaluation and management: CPT codes 90817, 90819, 90824, or 90827. Hospital calls are not appropriate with these procedure codes.

- A psychiatrist may bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- Psychiatrists may bill for one of the above psychotherapy procedures **or** a hospital call; **<u>not both</u>** unless there is a different diagnosis. Hospital calls (CPT codes 99231 through 99233) should be used for daily rounds.

- Physicians (who may or may not be psychiatrists) may bill state-unique code 9089M. This service is described as "certification activities related to an elective admission of clients younger than 21 years of age for inpatient psychiatric care."

- Psychiatric sleep therapy is not covered.

Office/Outpatient Setting

- MAA will reimburse for one interactive or insight-oriented call per client, per day in an office or outpatient setting.

- Clients may receive either:

  ✓ Office or outpatient psychotherapy only.

  Note: Use one of the following procedure codes when billing for only psychotherapy services: CPT code 90804, 90806, 90810, 90812, 90845, 90847, 90853, 90857, 90862, 90865, 90870, 90871, or state-unique code 9084M

  -OR-

  ✓ Psychotherapy with medical evaluation and management.

  Note: Use one of the following procedure codes when billing psychotherapy and medical evaluation and management: 90805, 90807, 90811, or 90813.

Limitations:

- MAA limits psychotherapy to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. Psychotherapy must be provided by a psychiatrist in the office, in the client's home, or in a nursing facility. Family therapy is covered only when the client is present.

  Note: Use one of the following psychotherapy CPT codes 90804, 90805, 90806, 90807, 90810, 90811, 90812, 90813, 90816, 90817, 90818, 90819, 90823, 90824, 90826, 90827, 90847, 90853, 90857, and 90899.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year unless a new mental health diagnosis occurs.

- The only psychiatric service MAA reimburses psychiatric ARNPs for is a medication adjustment (CPT code 90862).

- MAA reimburses psychiatrists and psychiatric ARNPs only for procedure codes and diagnosis codes that are within their scope of practice.

- Outpatient psychiatric services are not allowed for clients on the General Assistance (GAU) program, except for medication adjustment (CPT code 90862).

- Psychologists must use the MAA Psychologist Billing Instructions. MAA reimburses psychologists only for psychological evaluations. Psychological evaluation (state-unique code 0070M) is allowed once per client, per lifetime.

- Individual psychotherapy, interactive services (CPT codes 90810-90813, 90823-90824, 90826-90827) may be billed only for clients age 20 and younger.

Involuntary Treatment Act (ITA)

Physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using state-unique code 9084M.

- Physicians and psychiatrists may bill for a physical examination (state-unique code 9083M) in addition to CPT code 90801 (for adults) or 90802 (for children).

- A day's rounds along with any one of the following constitutes direct client care: narcosynthesis, brief (half-hour or one hour) individual psychotherapy, multiple/family group therapy, group therapy, chemotherapy, or electroconvulsive therapy.

- Payment will be made if the date of service is within 30 days from the date of detention. An extension form is required after 20 days of care. Extension approvals can be from the Regional Support Network (RSN), as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- The ITA form needs to include identification of the county of commitment, as well as some identification (signature or initials) of the County Designee completing the form. The physician or psychiatrist needs to complete Section I of the ITA Patient Claim Information form (DSHS 13-628x). If you need copies of this referral form, mail or fax a written request on letterhead to **DSHS Warehouse,** PO Box 45816, Olympia, WA 98504-5816, or FAX (360) 664-0597.

- MAA reimburses for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony will be paid per hearing. Use the ITA court testimony state-unique codes 9085M through 9087M to bill for time spent doing court testimony.

- Additional costs for court testimony are to be reimbursed from county ITA administrative funds.

- Out-of-state providers or border-area providers are not covered.

Podiatric Services

[Refer to WAC 388-531-1300]

- MAA reimburses podiatrists for procedure codes within their scope of care.

- MAA reimburses podiatrists for only those orthotics listed on page J114.

- Evaluation and Management (E&M) codes can be billed in addition to orthotics if the E&M services performed are justified and documented in the clients medical records.

- Medicare does not reimburse for orthotics and casting. You may bill MAA directly for those services without submitting a Medicare denial, unless the client's Medical ID card indicates *QMB - Medicare only*, in which case the orthotics and casting would not be covered by MAA.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

- Routine foot care is paid when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires that such care be performed by an M.D., D.O., or podiatrist.

  Examples of medical necessity include, but are not limited to:

  - ✓ Limitation of ambulation due to mycosis.
  - ✓ Likelihood that absence of treatment will result in significant medical complications.

MAA does <u>not cover</u> the following services:

- ✓ Treatment of flat feet; and
- ✓ Treatment of fungal (mycotic) disease is considered routine foot care and is not covered unless medical necessity is documented in the client's chart.

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the reimbursement for the surgical procedure and are not reimbursed separately.

- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period unless documented in the client's chart as medically necessary.

- MAA will reimburse podiatrists for covered, diagnostic, radiologic services of the ankle and foot if the client is examined before the x-ray is ordered. X-rays must be of sufficient quality to ensure ease of diagnosis, must be designated left and/or right, and dated and marked with the client's name for ready identification.

- MAA will not reimburse for the following radiology services:

  - ✓ X-rays for soft tissue diagnosis;
  - ✓ Bilateral x-rays for unilateral condition;
  - ✓ X-rays in excess of two views;
  - ✓ X-rays that are ordered before the client is examined; or
  - ✓ X-rays for any part of the body other than the foot or ankle.

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill MAA for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

New RNFA providers must meet the following critieria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to MAA along with the Core Provider Agreement:

    - Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
    - Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
    - Certification as a RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **do not need** to submit the Certification as a RNFA from the Certification Board Perioperative Nursing.

Radiology Services

[Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to postpay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

Contrast Material

Separate payment will not be made for contrast material (A4647) except in the case of low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure code A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents. See procedure codes listed in Section K.

Outpatient MRIs

You must bill using MAA's Expedited Prior Authorization (EPA) process for all outpatient MRIs. See Section I.

PET Scans

- MAA reimburses for Positron Emission Tomography (PET) scans only after prior authorization has been obtained. To request prior authorization see Section I.
- Effective for dates of service on or after July 1, 2001, the following new PET scan codes have been added and will be paid "By Report." MAA discontinued HCPCS codes G0126, G0163, G0164 and G0165. Replaced codes are noted.
- HCPCS code G0125 has a definition change: "PET Imaging whole body or regional; single pulmonary nodule."

HCPCS Code	Replaced HCPCS Code	Description
G0210		PET Imaging whole body; diagnosis; lung cancer, non-small cell
G0211	**G0126**	PET Imaging whole body; initial staging; lung cancer, non-small cell
G0212		PET Imaging whole body; initial staging; lung cancer; non-small cell
G0213		PET Imaging whole body; diagnosis; colorectal cancer
G0214		PET Imaging whole body; initial staging; colorectal cancer
G0215	**G0163**	PET Imaging whole body; restaging; colorectal cancer
G0216		PET Imaging whole body; diagnosis; melanoma
G0217		PET Imaging whole body; initial staging; melanoma
G0218	**G0165**	PET Imaging whole body; restaging; melanoma
G0219		PET Imaging whole body; melanoma for non-covered indications
G0220		PET Imaging whole body; diagnosis; lymphoma
G0221	**G0164**	PET Imaging whole body; initial staging; lymphoma
G0222	**G0164**	PET Imaging whole body; restaging; lymphoma
G0223		PET Imaging whole body or regional; diagnosis; head and neck cancer, excluding thyroid and CNS cancers
G0224		PET Imaging whole body or regional; initial staging; head and neck cancer; excluding thyroid and CNS cancers
G0225		PET Imaging whole body or regional; restaging; head and neck cancer; excluding thyroid and CNS cancers
G0226		PET Imaging whole body; diagnosis; esophageal cancer
G0227		PET Imaging whole body; initial staging; esophageal cancer
G0228		PET Imaging whole body; restaging; esophageal cancer
G0229		PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures
G0230		PET Imaging; metabolic assessment for myocardial viability following inconclusive SPECT study

Mammograms

MAA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms, CPT code 76092. For clients age 40 and over, one annual screening mammogram is allowed. Other screening mammograms may be allowed if determined medically necessary and documented in the client's record.

Digital Mammography

Effective with dates of service on or after July 1, 2001, MAA will pay for digital mammography using the following new 2001 HCPCS codes:

HCPCS Code	Description
G0202	Screening mammography producing direct digital image, bilateral, all views
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views
G0204	Diagnostic mammography, direct digital image, bilateral, all views
G0205	Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views
G0206	Diagnostic mammography, direct digital image, unilateral, all views
G0207	Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views

Bilateral Procedures for Radiology Modifiers

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT, if the procedure is defined as bilateral.

Anesthesia [Refer to WAC 388-531-0300(7)]

General anesthesia will be allowed for Magnetic Resonance Imaging (MRI), computerized tomography (CT), computerized axial tomography (CAT), and radiation therapy for children and/or noncooperative clients where the procedure cannot be performed unless the client is anesthetized.

Nuclear Medicine

When billing MAA for nuclear medicine, the multiple surgery rules will be applied when:

- The coding combinations listed below are billed:
  - ✓ For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or
  - ✓ With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below.
    - ➢ CPT code 78306 (bone imaging; whole body) and 78320 (bone imaging; SPECT);
    - ➢ CPT code 78802 (radionuclide localization of tumor; whole body) and 78803 (tumor localization; SPECT); and
    - ➢ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Consultation on X-Ray Examination

- When billing a consultation, the consulting physician must bill the specific radiological x-ray code with modifier 1R (professional component).

  For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT codes 71020-26), but the consulting physician would bill only for the chest x-ray consultations (e.g., 71020-1R).

Portable X-Rays

- Portable x-ray services furnished in clients' homes or nursing facilities are limited to the following tests:
  - ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  - ✓ Chest or abdominal films that do not involve the use of contrast media; or
  - ✓ Diagnostic mammograms.

- To bill for transportation of equipment, bill either HCPCS code R0070 (one patient, one unit) or HCPCS code R0075 (multiple patients, multiple units).

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA may pay laboratories only for MAA-certified tests.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number in order to receive reimbursement from MAA. Your claim for laboratory services cannot be paid unless your active CLIA identification number is on file with MAA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2802 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Seattle, WA 98155-9701
(206) 361-2802 or (206) 361-2813 FAX

Referenced Laboratory

If a laboratory sends a specimen to a referenced lab, you may bill for the referenced lab. However, the referenced lab provider number must be entered in the performing provider's number field. The referenced lab must be CLIA certified and have an active CLIA identification number on file with MAA. Use modifier 90.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Coverage Restrictions	Allowed Only With Diagnosis Code(s)
G0101	Females only	V76.2
G0102	Bundled	
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9 code other than high risk
G0104	Clients age 50 and older Allowed once every 48 months	Any valid ICD-9 code Other than high risk
G0105	Clients at high risk for colorectal cancer One every 24 months	High risk* 555.1, 555.0, 555.2, 555.9, 556.0-556.3, 556.8, 556.9, 558.2, 558.9 V10.05, V10.06, V16.0
G0106	Clients age 50 and older and not at high risk Once every 48 months	Any valid ICD-9 code Other than high risk
G0107	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9 code Other than high risk
G0120	Clients age 50 and older who are at high risk for colorectal cancer Once every 24 months	High risk* 555.1, 555.0, 555.2, 555.9, 556.0-556.3, 556.8, 556.9, 558.2, 558.9 V10.05, V10.06, V16.0
G0121	Once every 48 months.	Any valid ICD-9 code Other than high risk
G0122	None	Any valid ICD 9 code Other than high risk

MAA does **not cover** diagnosis codes V16 and V28.9

* Allowable diagnoses have changed in accordance with Medicare's guidelines.

Coding and Payment Policies

Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.

- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- MAA will reimburse for one blood drawing fee (CPT code 36415 or 36540) per day.
- MAA will reimburse for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- CPT codes 85007, 85009, 85014, 85018, 85021, 85027, 85041, and 85048 are included in the complete blood count procedure.
- CPT codes 81001, 81002, 81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT code 86817 allows a maximum of 15 tests for human leukocyte antigens (HLA) typing.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Reimbursement for lab tests includes handling, packaging and mailing fee. Separate reimbursement is not allowed.
- For **modifier 91**, see page E19.

Laboratory Services Referred by Community Mental Health Center (CMHC) Providers or Alcohol & Substance Abuse Providers

When CMHC or Alcohol & Substance Abuse providers refer Healthy Option clients for laboratory services, the laboratory must bill MAA directly, and the following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is directly related to the client's mental health or alcohol and substance abuse needs;
- The laboratory service is referred by a CMH provider who has a core provider agreement with MAA; and
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or Division of Alcohol and Substance Abuse (DASA) referring provider identification number assigned by MAA in **field 17a** on the HCFA-1500 claim form.

Direct entry and electronic billers must use the appropriate field.

Reimbursement

Reimbursement for laboratory services will be paid at the lesser of:

- The billed amount; or
- MAA's Maximum Allowble Fee.

When an independent laboratory goes to a nursing facility or a private home to obtain a specimen, an additional allowance may be billed using CPT code 99082.

Drug Screens

- MAA will reimburse for drug screens only when medically necessary and when ordered by a physician as part of a medical evaluation or when required drug and alcohol screens to assess suitability for medical tests or treatment.

- MAA will not reimburse for screens to monitor any of the following:

  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol abuse by a client when performed by a provider in a private practice; or
  - ✓ To monitor suspected drug use by clients in a residential setting such as a group home.

- For clients in the DASA contracted methadone treatment programs, drug screens are reimbursed through a contract issued by DASA, not through MAA.

Automated Multi-Channel Tests

MAA will reimburse for:

- CPT lab panel codes 80048, 80050, 80051, 80053, 80061, 80069, 80072, and 80076. The 22 individual automated multi-channel tests are:

Procedure Code	Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD),(LDH)
84075	Phosphatase, alkaline
84100	Phosphorus inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Triglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood

- You may bill a combination of panels and individual tests. However, do not bill separately for any individual tests that are included in the panel. Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see the next page:

Due to copyright restrictions, MAA publishes only short CPT descriptions.
To view the full CPT description, please refer to your current CPT manual.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy HCFA-1500 claim forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, and electronic submitters are allowed 21 lines per claim. **Use additional claim forms, if the services exceed the lines allowed.** Note the statement "additional services" in field 19 on the HCFA-1500 claim form or in the *Remarks/Comments* area, when billing electronically. MAA will review the claims for correct payment. *Total* each claim separately.

- If MAA pays a claim with one or more automated/nonautomated lab test, bill any additional automated/nonautomated lab tests for the same date of service on a blue Adjustment Request form (DSHS 525-109). Make sure you adjust the claim with the paid automated/nonautomated lab tests, using the comment "additional services."

If all services for **automated/non-automated lab tests** for the same date are denied, then follow the instructions in the first bullet on this page. If multiple claims are necessary and you are submitting on the HCFA-1500 paper claim, add the statement **additional services in box 19.**

For individual automated multi-channel tests (see previous page for list), providers will be paid on the basis of the total number of individual automated multi-channel tests performed for the same patient, on the same day, by the same laboratory. Each test must be billed as a separate line item on the claim form if:

1. Not all the procedures in a panel are performed;
2. There are additional automated multi-channel tests not included in a panel; or
3. There are other individual tests.

Reimbursement is based on the total number of tests.

For example:

- If five individual automated tests are billed, the reimbursement will be equal to the updated internal codes maximum allowable fee.

- If five individual automated tests and a panel that contains automated tests are billed, reimbursement will be the maximum allowable for the panel. Reimbursement for the individual tests, less any duplicates, will be equal to the internal codes maximum allowable fee.

If one automated multi-channel test is billed, reimbursement will be at the individual procedure code or internal codes maximum allowable fee, whichever is lower. The same will apply if the same automated multi-channel test is performed with modifier 91. (See page E19 for information on modifier 91.)

Non-Automated Multi-Channel

Organ and Disease Panels, CPT codes 80055, 80074, and 80090 do not include automated multi-channel tests. If all individual tests in the panel are not performed, reimbursement will be at the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The 19 non-automated multi-channel tests are:

CPT Code	Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85022	Automated hemogram
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

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To view the full CPT description, please refer to your current CPT manual.

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes. This modifier is used ***for information only***. **This modifier is <u>not</u> appropriate to use for billing repeat tests or to indicate not done as a panel.**

Modifier 90

- **<u>Reference (Outside) Laboratory</u>**: When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. *The referenced lab provider number must be entered in the performing number field on the HCFA-1500 claim form or electronic claim record. The referral lab must be CLIA certified.*

Modifier 91

- **Modifier 91 does affect payment**.

- Use this modifier:

  - ✓ Only for clinical laboratory tests; and
  - ✓ When repeat tests are performed on the same day, by the same provider, to obtain reportable test values with separate specimens taken at different times when it is necessary to obtain multiple results in the course of treatment. **Use modifier 91 with the appropriate procedure code for repeat tests.**

DO NOT USE THIS MODIFIER when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; **or**
- There are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Justification to bill modifier 91 must be maintained in the client's medical record.

Clinical Laboratory Codes

Nineteen clinical laboratory codes have both a professional component and a technical component. If performing only the technical portion, do not bill with a modifier. (The former TC is the global code in your fee schedule with no modifier.) The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Listed below are the 19 laboratory codes.

Code	Brief Description
83020	Hemoglobin electrophoresis
83912	Genetic examination
84165	Assay of serum proteins
84181	Western blot test
84182	Protein, western blot test
85390	Fibrinolysins screen
85576	Blood platelet aggregation
86255	Fluorescent antibody; screen
86256	Fluorescent antibody; titer
86320	Serum immunoelectrophoresis
86325	Other immunoelectrophoresis
86327	Immunoelectrophoresis assay
86334	Immunofixation procedure
87164	Dark field examination
87207	Smear, special stain
88371	Protein, western blot tissue
88372	Protein analysis w/probe
89060	Exam, synovial fluid crystals
P3001	Screening pap smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician

STAT Lab Charges

Laboratory services are covered under the RBRVS fee schedule. When laboratory tests are appropriately performed on a STAT basis, the provider may bill state-unique code 8949M. Reimbursement will be limited to one STAT charge per episode (not once per test). Tests must be ordered STAT and limited to only those that are needed to manage the patient in a true emergency. The laboratory report must contain the name of the provider who requested the STAT. The medical record must reflect the medical necessity and urgency of the service.

"STAT" Charges

Note: "STAT" must be clearly indicated by the physician and be documented on patient orders or records. Tests generated from the emergency room do not automatically justify a STAT order. Use state-unique code 8949M with the following procedure codes.

The STAT charge will be paid only with the tests listed below. Please refer to a CPT book for complete descriptions:

80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85007	Differential WBC count
85021	Automated hemogram
85022	Automated hemogram
85023	Automated hemogram
85024	Automated hemogram
85025	Automated hemogram
85027	Automated hemogram
85046	Automated hemogram
85378	Fibrin degradation
85384	Fibrinogen
85595	Platelet count, automated
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
88400	Bilirubin total transut
89051	Body fluid cell count

Prenatal Panels

- Do not use state-unique codes 8001M and 8002M; they are no longer valid.
- Use CPT code 80055 for prenatal panels.

Pap Smears

- Use CPT codes 88147-88154 and 88164-88167 for conventional Pap Smears.

- MAA reimburses for thin layer preparation CPT codes 88142-88145. HCPCS codes G0123, and G0143-G0145 remain noncovered. **Effective for claims with dates of service on and after October 1, 2001**, MAA reimburses for thin layer paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88154 and 88164-88167.

HIV Genotype and Phenotype Testing

- MAA reimburses for HIV Genotype and Phenotype testing using the following CPT procedure codes:

CPT Code	Description
87901	Genotype, dna, hiv reverse t
87903	Phenotype, dna hiv w/culture
87904	Phenotype, dna hiv w/clt add

- In addition, MAA reimburses for **Virtual HIV Phenotype** testing using the following state-unique code:

State-Unique Code	Description
8999M	Infectious agent virtual phenotype analysis, HIV 1

Maternity Care and Delivery

- A prenatal assessment (state-unique code 5930M) can be billed in addition to antepartum care. Only one prenatal assessment will be reimbursed per provider, per client, per pregnancy. MAA recommends that the Washington State Physicians Insurance Association (WSPIA) assessment form be used as a guide for your assessment.

- **Total obstetrical care (CPT code 59400) includes:**

  - ✓ Routine antepartum care in any trimester;
  - ✓ Delivery; and
  - ✓ Postpartum care.

- Bill a global obstetric procedure code after you have performed **all** of the services.

- Providers may also bill these routine antepartum services separately using the following state-unique codes and the appropriate CPT delivery only or delivery/postpartum only code.

  5951M - Routine antepartum care, first and/or second trimester, per month, up to a total of 6 per pregnancy.
  5952M - Routine antepartum care, third trimester, per month, up to a total of 3 per pregnancy.

  Note: Routine antepartum care should be billed in sequential months.
  Bill one unit per calendar month.
  Use a separate line for each calendar month, indicating the date of service.
  Three separate months of antepartum care equal one full trimester of care.

- If you provide all or part of an MAA client's antepartum and/or postpartum care, but do not perform the delivery, you must bill using the appropriate trimester or postpartum procedure codes. Bill **only** for the actual care you provided to a client.

- If you provide part of an MAA client's antepartum and postpartum care, and perform the delivery, you must bill only for the actual care you provided.

- **Antepartum care includes** prenatal services (initial and subsequent history, physical examination, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, maternity counseling).

- Necessary prenatal lab tests can be billed in addition to maternity services, **except urine dipstick tests (CPT codes 81000, 81001, 81002, 81003, and 81007).**

- Routine antepartum care procedure codes are not allowed in combination with any vaginal delivery or cesarean section procedure code that includes antepartum care.

- If a high-risk condition exists, bill the appropriate prenatal high-risk management code(s) in addition to routine antepartum care. When billing high-risk pregnancy codes, use an ICD-9-CM diagnosis code that reflects high-risk.

  A high-risk condition exists when a pregnant client:

  - Has a high-risk medical condition; and/or
  - Has a diagnosis of multiple births.

  If there is not an appropriate high-risk diagnosis code or the client's condition is not covered (e.g., obesity), use **V23.81-V23.9**.

- The following state-unique codes for the monthly high-risk add-on fees must be used according to the trimester of care.

  5953M - High-risk management, first trimester, add on, per month, up to a total of 3 per pregnancy.
  5954M - High-risk management, second trimester, add on, per month, up to a total of 3 per pregnancy.
  5955M - High-risk management, third trimester, add on, per month, up to a total of 3 per pregnancy.

  Note: High-risk management should be billed in sequential months.
  Bill one unit per calendar month.
  Use a separate line for each calendar month, indicating the date of service.
  Three separate months of high-risk management equals one full trimester of care.

- Medical problems during prenatal/trimester or postpartum care may require additional services. Bill for treatment of these problems using the Evaluation and Management (E&M) Services codes. MAA will reimburse for the medical services in addition to obstetrical care. Bill using the appropriate medical diagnosis.

- Bill MAA for consultations using consultation CPT codes 99241-99255. If a follow-up consultation is necessary, bill using CPT codes 99261-99263.

Maternity Case Management services are available through certain providers to help pregnant women gain access to medical, social, educational and other services. The Maternity Support Services program also supports these women. This program provides preventive health services in the home or clinic for women throughout pregnancy and up to 60 days after delivery.

For information on maternity case management services and maternity support services, call **MAA's Family Services Section at (360) 725-1655**.

Labor and Vaginal Delivery

- When a high-risk delivery condition exists, the procedure code for high-risk vaginal delivery add-on (state-unique code 5941M) can be billed in addition to routine vaginal delivery. You must also use an appropriate corresponding ICD-9-CM diagnosis code.

- Bill labor management (state-unique code 5935M) for care provided by the physician who has managed prenatal care but does not perform the delivery due to unanticipated medical complications. The client must be in active labor and must be admitted to a hospital or certified birthing facility when the referral to the delivering physician is made.

- Do not bill CPT code 59430 (postpartum care only) in addition to procedure codes that include postpartum care.

- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for 2nd or 3rd baby, use delivery only codes. Delivery only codes are paid at 50% of that procedure code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form, "twins" or "triplets."

- OB/GYN consultants may bill external cephalic version (CPT code 59412) and a consultation when performed on the same date of service.

- **To bill for anesthesia sesrvices during delivery**, see page F21.

- For deliveries in a Birthing Center refer to MAA's Births in Birthing Centers Billing Instructions. For deliveries in a home birth setting, refer to MAA's Planned Home Births Billing Instructions.

Cesarean Delivery

- MAA reimburses for multiple births at cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.

- Bill labor management (state-unique code 5935M) for care provided by the physician who has managed prenatal care but does not perform the cesarean section. The client must be in active labor and admitted to a hospital or licensed birthing center when the referral to the delivering physician is made.

- You may bill state-unique code 5959M for high-risk cesarean delivery add-on in addition to a cesarean delivery when a high-risk delivery condition exists and the appropriate ICD-9-CM diagnosis code is used. A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.

- If you have performed the antepartum and postpartum care and assisted at cesarean delivery, use state-unique code 5947M. Do not use modifier 80.

- Do not bill postpartum care only (CPT code 59430), in addition to procedure codes that include postpartum care.

- **To bill for anesthesia services during delivery**, see page F21.

- Physician assistants must bill for an assist for a C Section delivery on the same claim form as the physician using modifiers 80, 81 or 82.

- RNFAs bill for cesarean sections using modifier 80.

Abortion Services (Drug Induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions. The following HCPCS codes must be billed at acquisition cost. **(Keep invoice on file.)**

  ✓ J9260 Methotrexate sodium, 50 mg.
  ✓ S0191 Misoprostol, oral, 200 mcg.

- Professional services, laboratory charges, and ultrasound must be billed by the performing provider under his or her individual provider number, using the appropriate CPT codes.

- Rho(D) immune globulin serums must be billed using the appropriate HCPCS J-codes. Please note that applicable pre- and post-operative visits are included in the surgical fee (global surgery policy).

- When these drugs are used for abortion services, providers must indicate on electronic billing or on the HCFA-1500 claim form the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be charted and billed at the same time as the abortion procedure.

- **RU-486 Abortion Drug**

  MAA pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests and diagnostic tests performed for the purpose of confirming pregnancy, gestational age and successful termination must be billed separately using the appropriate CPT codes.

- **Bill all RU-486 charges per client, per pregnancy on the same claim form.**

HCPCS Code	Description	Maximum Allowable Fee
S0190	Mifepristone, oral, 200 mg	Acquisition Cost
S0191	Misoprostol, oral, 200 mcg	Acquisition Cost

Special Agreements (Facility Fees)

- For providers who currently have a special agreement with MAA, facility fees are payable **only** for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention.

- Please remember that the special agreement facility fee reimbursement includes all room charges, equipment, supplies and drugs (including anti-anxiety and anesthesia agents and pain medications, but excluding Rho(D) immune globulin serums). **You may bill only one special agreement facility fee per client, per abortion**. The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete. MAA recoups any duplicate or extraneous payments.

Chemotherapy Services

[Refer to WAC 388-531-0950(11)]

When chemotherapy is administered in the physician's office, but there is no face-to-face contact with the physician, the E&M CPT code 99211 may be used to bill for this service if:

- The physician personally supervises the E/M services furnished by office medical staff; and
- The medical record reflects the physician's active participation in or management of course of treatment.

See the listing of J & Q injection drug codes in this document. Use the following procedures to bill for chemotherapy drugs (HCPCS codes J9000-J9999):

- The definition of the unit of service is based on the HCPCS descriptions;
- Maximum allowable is 95% of Medicare's rate.

This method of setting the maximum allowable payment rates is based on the current methodology used to set the payment rates for prescription drugs under MAA's Prescription Drug Program. MAA sets this level of payment to take into consideration the cost of the drug. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less. The same basis for payment (per unit) is used for both single and multi dose vials, but the unit allowance would vary by drug.

I. Single Dose Vials:

For single dose vials, bill the total amount of the drug contained in the vial(s) used including partial vials. The HCPCS descriptions for the J Codes (J9000 through J9999) establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 150 mg of Etoposide were required for the therapy, and two 100 mg single dose vials were required to obtain the total dosage, then the total of the two 100 mg vials would be billable. In this case, the procedure would be billed under J9181 (Etoposide, 10 mg), with the maximum allowable price at $4.38 per 10 mg unit, the total allowable would be $87.60. (200 mg divided by 10 = 20 units x $4.38). This would then be compared to the billed amount.

II. Multi-Dose Vials:

For multi dose vials, bill only the number of units (rounded to the nearest whole unit) of the drug used. The HCPCS descriptions for the J Codes (J9000 through J9999) establish the unit of service. Based on this unit definition, the maximum allowable per unit is MAA's maximum allowable price. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Example:

If a total of 750 mg of Cytarabine were required for the therapy, and was taken from a 2,000 mg multi dose vial, then only the 750 mg used would be billable. In this case, the procedure would be billed under J9110 (Cytarabine, 500 mg), with the maximum allowable price at $23.75 per 500 mg unit, the total allowable would be $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

III. Unlisted Drugs:

When there is no J Code available to define the drug used and unit of service, the provider determines the number of units used and bills total units. Claims must include the drug used, dosage, strength and the National Drug Code (NDC) in the *Comments* field. Claims will be denied if the information is not included on the claim. The NDC for the drug determines the total allowable by using MAA's pricing multiplied by the number of units billed. The same policies regarding the billing of single and multidose vials apply. MAA's payment is the billed amount or MAA's maximum allowable rate, whichever is less.

Oral Anti-Emetic Drugs

In order to bill MAA for HCPCS codes Q0163 through Q0181, the drug must be:

1. Part of a cancer chemotherapy regimen, administered or prescribed for use immediately before, during, or within 48 hours after the time of administration of the chemotherapeutic agent;

2. Covered by a valid diagnosis code. [Valid diagnosis codes are 140.0 through 239.9, (excluding 210.0 through 229.9) and V58.1]; and

3. Submitted on the same claim form with one of the anti-neoplastic (cancer) drug procedure codes J8530 through J9999.

Hydration Therapy and Chemotherapy

Intravenous (IV) infusion of saline, an anti-emetic, or any other non-chemotherapy drug (CPT codes 90780 and 90781) is not reimbursed separately when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate reimbursement will be allowed for IV infusion when administered on the same day but **before or after** rather than at the same time as the chemotherapy infusion. Use modifier 59 to indicate IV infusion was performed sequentially.

Surgical Services

[Refer to WAC 388-531-1700]

Global Surgery Policy - Global surgery reimbursement includes all the following services:

- The operation itself.
- Preoperative visits for major surgeries, in or out of the hospital, beginning on the *day before* surgery.
- Preoperative visits for minor surgeries beginning on the *day of* surgery.
- Services by the primary surgeon, in or out of the hospital during the postoperative period.
- Postoperative dressing changes, including:

  - ✓ Local incision care and removal of operative packs;
  - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes;
  - ✓ Change and removal of tracheostomy tubes;
- All additional medical or surgical services required because of complications that do not require additional operating room procedures.

☞ **Note:** Casting materials are not part of the global surgery policy and are paid separately

Global Surgery Reimbursement

1. The global surgery reimbursement period applies to any provider who participated in the surgical procedure. These providers include:

   - Surgeon
   - Assistant surgeon (modifiers 80, 81, or 82)
   - Two surgeons (modifier 62)
   - Team surgeons (modifier 66)
   - Anesthesiologists and CRNAs

2. The following procedure codes are included in the global surgery reimbursement period unless E&M is billed with a modifier. (See modifiers below for E&M.)

E&M CPT Code

99211 through 99223
99231 through 99239
99241 through 99245
99251 through 99255
99261 through 99263
99271 through 99275
99291 through 99292
99301 through 99303
99311 through 99316
99331 through 99333
99347 through 99353
99374 through 99375
99377

Ophthalmological CPT Codes

92012 and 92014

Modifier	**Description**
24	Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)
57	Decision for surgery (only applies to surgeries with a 90-day global period)
79	Unrelated procedure or service by the same physician during the postoperative period

Professional inpatient services (CPT codes 99221 through 99223) are payable only during the follow-up day period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).

Procedure codes that are considered *bundled* are **not payable** during the global surgery reimbursement period.

A physician, other than the surgeon, who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care and the surgical code with modifier 55 for the post-discharge care. **The surgeon should bill the surgery code with modifier 54.**

Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of E&M code. These services are not included in the global surgical reimbursement.

The physician who performs the emergency room service must bill for the surgical procedure without using modifier 54.

3. Preoperative and postoperative critical care services provided during a global period for a seriously injured or burned client are not considered related to a surgical procedure and may be paid separately under the following circumstances:

   Preoperative and postoperative critical care may be paid in addition to a global fee if all of the following apply:

   - The client is critically ill and requires the constant attendance of the physician;
   - The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
   - Such clients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

   Modifiers 24 or 25 must be used to indicate these critical care services (reason for the E&M service must be unrelated to the procedure).

4. Separate reimbursement is allowed for:

   - The initial evaluation to determine need for surgery.
   - The preoperative visits prior to one day before the surgery.
   - Postoperative visits for problems *unrelated* to the surgery.
   - Postoperative visit for services that are not included in the normal course of treatment for the surgery.
   - Services of other physicians, except when services included in a global package are furnished by more than one physician. (See modifiers 54 and 55)

   For endoscopic procedures and minor surgery for which global surgical payment policy has not been generally used, payments are not allowed for a visit on the same day of the surgical or endoscopic procedure unless a documented, separately identifiable service is provided.

Multiple Surgery

When multiple surgeries are performed on the same client, at the same operative session, total payment equals the sum of 100% of the global fee for the highest value procedure. Reimbursement for the second through the fifth surgical procedures is 50% of the global fee.

To expedite payment of your claim, bill all the surgeries for the same operative session on the same claim.

When multiple dermatological procedures are performed, the first procedure is paid at 100%, and at 50% for each additional procedure.

If a partial payment is made on a claim with multiple surgeries, you must rebill MAA using a blue Adjustment Request form (DSHS 525-109).

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc. are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.
- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules apply.
- When surgical procedures are performed in the same operative session, the multiple surgery rules apply.
- When payment for other codes within a endoscopy group is less than the endoscopy base code, no payment is made.
- MAA does not reimburse for an E&M visit on the same day as the diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier 25 is used (reason for the E&M service must be unrelated to the procedure).

Other Surgical Policies

- Use modifiers 80, 81 and/or 82 to indicate surgery assist procedures. An assist at major surgery by a physician is paid at 20% of the listed value for the surgical procedure. The multiple surgery rules apply for surgery assists.

- **All claims for sterilization and hysterectomy procedures must be accompanied by a completed consent form. (See Section I.)**

- Use of operating microscope, CPT code 69990, replaced CPT codes 61712 and 64830. CPT code 69990 will be reimbursed only when billed with one of the following CPT codes: 61304-61711, 62010-62100, 63081-63308, 63704-63710, or 64831-64907.

- The following surgeries are allowed only with diagnoses V10.3, 140.0-239.9, 757.6, 759.4, 906.5-906.9, or 940.0-949.5.

CPT Code(s)	Description
11960	Insertion of tissue expander(s)
11970	Replace tissue expander
11971	Remove tissue expander(s)
19160	Removal of breast tissue
19162	Remove breast tissue, nodes
19180	Removal of breast
19182	Removal of breast
19316	Suspension of breast
19340	Immediate breast prosthesis
19342	Delayed breast prosthesis
19350	Breast reconstruction
19357	Breast reconstruction
19361	Breast reconstruction
19364	Breast reconstruction
19366	Breast reconstruction
19367	Breast reconstruction
19368	Breast reconstruction
19369	Breast reconstruction
19370	Surgery of breast capsule
19371	Removal of breast capsule
19380	Revise breast reconstruction

- Salpingostomy, CPT code 58770 is payable only for a tubal pregnancy (diagnosis code 633.1).

- Modifier 53 must be used when billing incomplete colonoscopies (CPT code 45378). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 only. It is "information only" for all other surgical procedures.

Epiphyseal

Surgical procedures for epiphyseal (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not reimbursed when billed with enterostomy codes (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140 through 44147).

Angioscopy

- MAA reimburses for one unit of angioscopy (CPT code 35400), per session.

Apheresis **(CPT code 36520)**

Therapeutic apheresis (CPT code 36520) includes payment for all medical management services provided to the patient on the date of service. MAA reimburses for only one unit of CPT code 36520 for the same physician on the same date for the same patient.

Separate payment is not allowed on the same date that therapeutic apheresis services are provided, unless they are billed with a modifier 25 (reason for the E&M service must be unrelated to the procedure) for the following:

- Established patient office and other outpatient visits (CPT codes 99211-99215);
- Subsequent hospital care (CPT codes 99231-99233); and
- Follow-up inpatient consultations (CPT codes 99261-99263).

Do not bill apheresis management when billing for critical care (99291 and 99292) time.

Bilateral Procedures

- If a procedure **is not** identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier 50. Bill as a single line item.
- If a procedure **is** identified by the terminology as bilateral (or unilateral or bilateral), as in CPT codes 27395 and 52290, do not report the procedure with modifier 50.
- Use Modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

- Within each range of procedure codes, there are *two* possible pre-/intra-/postoperative payment splits.

- These payment splits are made when modifiers 54, 55, and 56 are used.

- One possible payment split is 10% 80% 10%. The *other* possible split for each range is displayed below:

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	70%	20%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37799	Cardiovascular	09%	84%	07%
38100 - 38999	Hemic & Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum	09%	84%	07%
40490 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 – 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	61%	22%
60000 - 60699	Endocrine	09%	82%	09%
61000 - 64999	Nervous	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Anesthesia [Refer WAC 388-531-0300]

- General anesthesia is allowed for Magnetic Resonance Imaging (MRI), computerized tomography (CT), computerized axial tomography (CAT), and radiation therapy for children and/or noncooperative clients when the procedure cannot be performed unless the client is anesthetized.

- Surgeons, anesthesiologists and advanced registered nurse practitioners (ARNPs) with a certification in anesthesia must have individual provider numbers in order to be reimbursed for services.

- For each patient, the anesthesia provider must:
  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform, are performed by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post anesthesia care.

- In addition, the anesthesiologist may direct no more than four anesthesia services concurrently. The physician may not perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.

- The anesthesia provider must document in the patient's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate requirements were met.

- Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continous monitoring of the patient within the blocks of time. Examples of this include, but are not limited to, time a patient spends in an anesthesia induction room; or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesiologist, surgeon or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- Do not bill CPT codes 01996 or 01953 with an anesthesia modifier. MAA has assigned flat fees for these codes. Do not bill time in the units field for CPT codes 01996 or 01953.

Coding and payment policies

General Anesthesia

MAA requires providers to use Anesthesia CPT codes 00100 through 01999 to bill for anesthesia services paid with base and time units. In addition to the Anesthesia CPT codes, MAA accepts two anesthesia codes published in the ASA RVG:

ASA Code	ASA RVG Description
01961	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
01962	Anesthesia for diagnostic or therapeutic nerve blocks and injections - patient in the prone position (when block or injection is performed by a different provider)

Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia. MAA does not adopt any other ASA RVG codes that are not included in CPT. Bill all other anesthesia codes according to the descriptions published in CPT. When there are differences in code descriptions between CPT and ASA RVG, MAA follows CPT descriptions. MAA does not reimburse for anesthesia services when billed with the CPT surgery, radiology and medicine codes. **Continue to use the appropriate anesthesia modifier with Anesthesia CPT and ASA codes.**

> Exception: Continue to bill CPT Pain Management/Other Services codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the units field or use anesthesia modifiers.

Below are the state-unique anesthesia codes with associated CPT surgical codes that must be used:

Procedure	State-Unique Code	CPT Codes
Vasectomies	5911M	54690, 55250, and 55450
Sterilizations	5912M	58600, 58605, 58611, 58615, 58670 and 58671
Hysterectomies	5913M	51925, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550 and 59135
Hysterectomies	5914M	58200, 58210, 58240, 58285 and 59525
The above procedures must have valid consent forms attached to the claim form.		
Abortions	5915M	59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857

- Do not bill Anesthesia CPT or ASA RVG for vasectomies, sterilizations, and hysterectomies or abortions. Bill the appropriate anesthesia modifier with the anesthesia state-unique code. When billing state-unique abortion code 5915M, indicate in field 19 of the HCFA-1500 claim form or in the **Comments** field for direct entry, magnetic tape or EMC "voluntary or induced abortion."

- MAA does not reimburse for anesthesia CPT codes 00855 and 00944.

- Do not bill CPT codes 00800-00884, 00920-00955 for abortions, hysterectomies, or sterilizations.

- When multiple surgical procedures are performed during the same period of anesthesia, the surgical procedure with the greatest base value should be billed, along with the total time in whole minutes.

- If anesthesia time exceeds 999 minutes, leave the units field blank. Enter the time in the **Remarks** field or enter beginning and ending time or total minutes on the HCFA-1500 claim form.

- When more than one anesthesia provider is present, MAA pays the supervisory anesthesiologist and the certified registered nurse (CRNA) each 50% of the allowed amount. MAA limits reimbursement in this circumstance to 100% of the total allowed reimbursement for the service.

- The anesthesia payment system is based on a per minute reporting assumption. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is not longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- Providers must report the number of actual anesthesia minutes (calculates to the next whole minute) in field 24G of the HCFA-1500 claim form. MAA calculates the base units.

Regional Anesthesia

- Bill MAA the appropriate CPT code (e.g., epidural-CPT code 62319) with no time units and no anesthesia modifier. MAA determines payment by using only RBRVS, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the package for the surgical procedure and is not reimbursed separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- MAA follows the Centers for Medicare and Medicaid Services (CMS's) policy to not reimburse surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon **is not allowed**. These services are considered included in the RBRVS payment for the procedure.

- When billing for anesthesia services using CPT anesthesia code 01999, submit documentation (operative report) indicating what surgical procedure was performed that require the anesthesia. An MAA Medical Consultant will review documentation for determination of payment.

Anesthesia for Maternity [Refer to WAC 388-531-0300(9)]

- MAA reimburses anesthesia for a maximum of 6 hours (360 minutes) per delivery, including multiple births and/or Cesarean section delivery. In order to be reimbursed, bill the applicable Labor and Delivery CPT Anesthesia code with modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- MAA does not apply the 6-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

- Anesthesia time for sterilization is added to the time for the delivery and the 6-hour limit, when the two procedures are performed during one operative session. If the sterilization and delivery are performed in different operative sessions, the time is calculated separately.

☞ **Note:** Anesthesia for maternity services are reimbursed under RBRVS or according to ASA RVG base unit value.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- The conversion factor is $15.49.

- Anesthesia time is paid using **one minute per unit**.

- The total anesthesia reimbursement rate is calculated by adding the base value for anesthesia listed in this fee schedule with the actual time. Bill time in **total minutes** to the next whole minute, not hours and minutes or multiple-minute units. Do not bill base. The formula for calculating anesthesia payment using total minutes is described later in this section.

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation
A. Multiply base units by **15.**
B. Add total minutes to value from step A.
C. Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D. Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Dental Anesthesia

General anesthesia is allowed when provided by an anesthesiologist or a Certified Registered Nurse Anesthesist (CRNA) for dental admissions. Use CPT anesthesia code 00170 with the appropriate anesthesia modifier.

> **Note:** Bill MAA directly for dental anesthesia for all clients, including those enrolled in managed care.

Pain Management Services

- Pain management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are *not* paid with anesthesia base and time units. **Do not use anesthesia modifiers when billing for services payable only under RBRVS**. If an anesthesia modifier is used with a code that is payable only under RBRVS, MAA will deny the service.

- Two postoperative epidurals and two hospital follow-up calls are allowed for pain management. Only one (1) unit may be billed per epidural, e.g., 62319; this is billed as a procedure. Do NOT bill time. **Use modifier 59** to indicate epidurals for pain management.

See next page for Pain Management Procedure Codes

Pain Management Services (cont.)

Due to copyright restrictions, MAA publishes only short CPT descriptions.
To view the full CPT description, please refer to your current CPT manual.

The listings shown below are not guaranteed to be all-inclusive, and are provided for convenience purposes only. Do not rely solely on the descriptions given in the appendices for complete coding information. Please refer to a current CPT book for complete coding information.

Use modifier 59 to indicate that an epidural was done as a separate procedure for pain management.

CPT Code	Description	CPT Code	Description
20550	Inject tendon/ligament/cyst	64410	Injection for nerve block
20600	Drain/inject, joint/bursa	64412	Injection for nerve block
20605	Drain/inject, joint/bursa	64413	Injection for nerve block
20610	Drain/inject, joint/bursa	64415	Injection for nerve block
27096	Inject sacroiliac joint	64417	Injection for nerve block
61790	Treat trigeminal nerve	64418	Injection for nerve block
62263	Lysis epidural adhesions	64420	Injection for nerve block
62270	Spinal fluid tap, diagnostic	64421	Injection for nerve block
62272	Drain spinal fluid	64425	Injection for nerve block
62273	Treat epidural spine lesion	64430	Injection for nerve block
62280	Treat spinal cord lesion	64435	Injection for nerve block
62281	Treat spinal cord lesion	64445	Injection for nerve block
62282	Treat spinal canal lesion	64450	Injection for nerve block
62284	Injection for myelogram	64470	Inj paravertebral c/t
62287	Percutaneous diskectomy	64472	Inj paravertebral c/t add on
62290	Inject for spine disk x-ray	64475	Inj paravertebral l/s
62291	Inject for spine disk x-ray	64476	Inj paravertebral l/s add-on
62310	Inject spine c/t	64479	Inj foramen epidural add-on
62311	Inject spine l/s (cd)	64480	Inj foramen epidural add-on
62318	Inject spine w/cath, c/t	64483	Inj foramen epidural l/s
62319	Inject spine w/cath l/s (cd)	64484	Inj foramen epidural add on
62350	Implant spinal canal cath	64505	Injection for nerve block
62351	Implant spinal canal cath	64508	Injection for nerve block
62355	Remove spinal canal cath	64510	Injection for nerve block
62360	Insert spine infusion device	64520	Injection for nerve block
62361	Implant spine infusion pump	64530	Injection for nerve block
62362	Implant spine infusion pump	64550	Apply neurostimulator
62365	Remove spine infusion device	64555	Implant neuroelectrodes
63600	Remove spinal cord lesion	64560	Implant neuroelectrodes
63650	Implant neuroelectrodes	64573	Implant neuroelectrodes
63655	Implant neuroelectrodes	64575	Implant neuroelectrodes
63660	Revise/remove neuroelectrode	64577	Implant neuroelectrodes
63685	Implant neuroreceiver	64580	Implant neuroelectrodes
63688	Revise/remove neuroreceiver	64585	Revise/remove neuroelectrode
64400	Injection for nerve block	64590	Implant neuroreceiver
64402	Injection for nerve block	64595	Revise/remove neuroreceiver
64405	Injection for nerve block	64600	Injection treatment of nerve
64408	Injection for nerve block	64605	Injection treatment of nerve

CPT Code	Description	CPT Code	Description

Pain Management Services (cont.)

64610	Injection treatment of nerve
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
64620	Injection treatment of nerve
64622	Destr paravertbrl nerve l/s
64626	Destr paravertbrl nerve c/t
64627	Destr paravertbrl nerve add-on
64630	Injection treatment of nerve
64640	Injection treatment of nerve
64680	Injection treatment of nerve
64802	Remove sympathetic nerves
64804	Remove sympathetic nerves
64809	Remove sympathetic nerves
64818	Remove sympathetic nerves
76000	Fluoroscope examination
76003	Needle locatlization by x-ray
76005	Fluoroguide for spine inject
95970	Analyze neurostim, no prog

Other Services

31500	Insert emergency airway
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36488	Insertion of catheter, vein
36489	Insertion of catheter, vein
36490	Insertion of catheter, vein
36491	Insertion of catheter, vein
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
93503	Insert/place heart catheter

These codes will be paid under RBRVS as the procedure.

Major Trauma Services

Payment enhancements apply to non-governmental Trauma Services. Physicians and clinical providers on the Trauma teams of governmental hospitals receive enhancements on a per-patient basis. See page F27 for a list of the Designated Trauma Services. Page F28 lists DOH's categories of Physician and Clinical Providers for the Trauma Response Teams.

Payment Limitations for Major Trauma

To receive enhanced payment, the Department of Health (DOH) must identify the facility as a Designated Trauma Services. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' Injury Severity Score (ISS) will be done by DOH.

Enhanced payments are limited to services provided by a member of a Designated Trauma Services Trauma Response Team for Medical Assistance clients who require major trauma services. (See the Physician/Clinical Provider List, page F28.) Enhanced payments are limited to services performed in the hospital.

These enhancements are for fee-for-service MAA clients only. MAA clients covered by managed care plans have trauma payments included in their managed care rates. Providers have contracts with these managed care plans that may or may not include additional payments for various services such as major trauma.

Non-Designated Centers and Providers

Physicians, and clinical providers not identified by DOH as Designated Trauma Services will continue to be reimbursed at the standard rates for Medical Assistance clients. A non-designated clinic that becomes designated during the course of the year must notify the Provider Enrollment Unit, PO Box 45562, Olympia, WA 98504-5562 of the change in status.

Billing

Physicians/Clinics and Other Professionals: Under certain circumstances, two or more modifiers may be necessary to completely describe a service. When that occurs, add modifier 99 to the detail line along with all other applicable modifiers, including 9T. Billing all modifiers with modifier 99 ensures appropriate payment. Claims billed inappropriately must be rebilled on MAA's blue Adjustment Request Form (DSHS 525-109).

In addition to the procedure code, enter the appropriate condition code or modifier as follows:

Type of Claim	Claim Form	Code/Modifier	Where on claim?
Physicians/ Clinical Providers	HCFA-1500	Modifier **9T** *Enter this for each detail line that applies.*	Field 24d

Additional funds <u>are</u> available for treatment related to major trauma at Designated Trauma Services; however, modifier 9T must be entered on the claim form to receive the enhanced payment.

Note: The current Injury Severity Score (ISS) is 9. Enhanced payment is available for ALL cases with an ISS of 9 or above.

For Additional Information

For information on **trauma service designation, trauma registry and/or injury severity scores (ISS),** contact:

Chris Williams
Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or 1-800-725-1834.

For information on **reimbursement**, contact:

Tom Johnson
MAA Reimbursement Section
(360) 725-1834

For information on a specific **Medicaid trauma claim**, contact:

MAA's Provider Relations Unit
1-800-562-6188.

DESIGNATED TRAUMA SERVICES

Non-governmental Facilities:

Auburn Regional (Auburn)
Cascade Medical (Leavenworth)
Central Washington (Wenatchee)
Darrington (Darrington)
Deaconess (Spokane)
Deer Park (Deer Park)
Emanual (Portland)
Good Samaritan (Puyallup)
Grays Harbor Community (Aberdeen)
Gritman Memorial (Moscow, Idaho)
Harrison Memorial (Bremerton)
Highline Community (Burien)
Holy Family (Spokane)
Inter-Island (Friday Harbor)
Kadlec (Richland)
Mary Bridge's (Tacoma)
Mt. Carmel (Colville)
Northwest (Seattle)
Our Lady of Lourdes (Pasco)
Overlake (Bellevue)
Providence (Centralia)
Providence (Everett - Colby)
Providence (Toppenish)
Sacred Heart (Spokane)
St. Francis (Federal Way)
St. Johns (Longview)
St. Joseph (Bellingham)
St. Joseph (Chewelah)
St. Joseph (Lewiston)
St. Mary Med. Ctr. (Walla Walla)
St. Peter's (Olympia)
Southwest Wash. (Vancouver)
Sunnyside Community (Sunnyside)
Tri-State Memorial (Clarkston)
Valley (Spokane)
Walla Walla General (Walla Walla)
Yakima Valley/Prov Yak Med (Yakima)

Governmental Facilities and their Trauma Service Level:

Level 1:
Harborview (Seattle)
Oregon Health Sciences (Portland)
*** Designated by Oregon only**

Level 2:
None

Level 3:
Island (Anacortes)
Kennewick General (Kennewick)
Skagit Valley (Mt. Vernon)
Valley Med. Ctr. (Renton)
Whidbey General (Coupeville)

Level 4:
Cascade Valley (Arlington)
Evergreen Hospital (Kirkland)
Forks Community (Forks)
Jefferson General (Pt. Townsend)
Kittitas Valley (Cle Elum)
Klickitat Valley (Goldendale)
Lake Chelan Community (Chelan)
Lewis Co. Hosp. Dist. #1 (Morton)
Lincoln (Davenport)
Mason General (Shelton)
Mid Valley (Omak)
Newport Comm. Hospital (Newport)
North Valley (Tonasket)
Ocean Beach (Ilwaco)
Okanogan-Douglas (Brewster)
Olympic Mem. Hospital (Pt. Angeles)
Othello Community (Othello)
Prosser Memorial (Prosser)
Pullman Memorial (Pullman)
Samaritan (Moses Lake)
Skyline (White Salmon)
Stevens Memorial (Edmonds)
Valley General (Monroe)
Willapa Harbor Hosp. (South Bend)

Level 5:
Columbia Basin (Ephrata)
Coulee Community (Grand Coulee)
Dayton General (Dayton)
East Adams Rural (Ritzville)
Ferry Co. Memorial (Republic)
Garfield County (Pomeroy)
Kittitas Hosp. Dist. #2 (Cle Elum)
Mark Reed (McCleary)
Odessa Memorial (Odessa)
Quincy Valley (Quincy)
Whitman County (Colfax)

PHYSICIAN / CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Certified Registered Nurse Anesthetist
Cardiologist
Critical Care Physician
Emergency Physician
Family/General Practice Physician with Trauma Training
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pathologist
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Note: Laboratory procedures are not included in major trauma services enhanced payment.

Physical Therapy

Which physicians are eligible to provide physical therapy?

[Refer to WAC 388-545-500(1)]

- Licensed physiatrists.

Where must physical therapy services be provided?

[WAC 388-545-500(3)(a-f)]

Physical therapy services that Medical Assistance Administration (MAA) eligible clients receive must be provided as part of an outpatient treatment program:

- In an office, home, or outpatient hospital setting;
- By a home health agency as described in Chapter 388-551 WAC;
- As part of the acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC;
- By a neurodevelopmental center;
- By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-86-022; or
- For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500(5)]

Providers must document in a client's medical file that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

<u>Children (Age 20 and younger)</u> (Refer to WAC 388-86-027)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's physical therapy file.

The physiatrist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT screening provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Coverage [WAC 388-545-500(4)]

MAA pays only for covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards. [WAC 388-545-500(4)]

What is covered? [Refer to WAC 388-545-500(7-8)]

☞ **Note:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

- MAA does not limit covered physical therapy services if the client is 20 years of age or younger.
- MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year for clients 21 years of age and older:
  - ✓ One physical therapy evaluation. The evaluation is in addition to the 48 program units allowed per year;
  - ✓ 48 physical therapy program units; and
  - ✓ 96 additional outpatient physical therapy program units for the diagnoses listed on the following page.
- MAA will pay for one visit to instruct in the application of transcutaneous electrical neurostimulator (TENS) per client, per lifetime.
- MAA covers two DME needs assessments per calendar year. Two physical therapy program units are allowed per assessment.
- MAA covers one wheelchair needs assessment in addition to the DME needs assessment per calendar year. Four physical therapy program units are allowed per assessment.

Additional Coverage (Client 21 years of age and older)

MAA covers a maximum of 96 physical therapy program units in addition to the original 48 units only when billed with one of the following diagnoses:

- **Principal** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
890-897.7, 887.6-887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

> ☞ **Note:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

The following are considered part of the 48 physical therapy program unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028);
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039);
- Therapeutic exercises (CPT codes 97110-97139);
- Manual therapy (CPT code 97140);
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530);
- Self care/home management training (CPT code 97535);
- Community/work reintegration training (CPT code 97537);
- Therapeutic procedures (CPT code 97150); and

Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).
[WAC 388-545-500(11)]

The following are not included in the 48 physical therapy program unit limitation:

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Checkout for orthotic/prosthetic use (CPT code 97703). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Muscle testing (CPT codes 95831-95852). One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Evaluation of physical therapy (CPT code 97001). Allowed once per calendar year, per client. CPT code 97001 is for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This evaluation is for evaluating the patient's condition and establishing the plan of care.

- Re-evaluation of physical therapy (CPT code 97002). CPT code 97002 is for reporting the reevaluation of a patient who has been under a plan of care established by a physician or physical therapist. This evaluation is for reevaluating the patient's condition and revising the plan of care under which the patient is being treated.

- Wheelchair needs assessments (CPT code 97703). One allowed per calendar year. Four physical therapy program units are allowed per assessment. Indicate on claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two physical therapy program units are allowed per assessment. Indicate on claim the type of assessment.

[Refer to WAC 388-545-500 (8)]

Effective with dates of service on or after January 1, 2001, MAA reimburses for active wound care management (CPT codes 97601-97602) only when performed by a physical therapist.

- Must be provided by a physical therapist;
- Do not bill CPT code 97601 and 97602 in combination with each other;
- Do not bill CPT code 97601 and 97602 in combination with debridement codes 11040 and 11044);
- MAA reimburses for either one unit of CPT code 97601 or one unit of CPT code 97602 per day.

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits. See Section I - Authorization.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

- MAA does not reimburse separately for physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Supplies

Office Supplies

- See page K17 for supplies that can be billed individually.
- Procedure codes for supplies under $50.00 that do not have a fee listed will be reimbursed at acquisition cost; an invoice must be retained in the provider's file. An invoice must be submitted with the claim for supplies costing $50.00 or more.
- A surgical tray may be billed separately by using HCPCS code A4550, but only for certain surgical services. Those that MAA does not reimburse separately are included in the surgery fee (see page K9).

Casting Materials

- Use state-unique codes 2978M through 2987M for fiberglass and plaster casting materials (see page K2). **Do not bill for the use of a cast room.** Use of a cast room is considered part of a provider's practice expense.

Catheter Supplies

- Separate payment is allowed for a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office. Use HCPCS procedure code G0002 to bill for this supply.
- MAA does not cover this procedure when it is performed on the same day as, or during the postoperative period of, a major surgical procedure.

Miscellaneous Services

DDD Physical: One physical (state-unique code 0310M) is allowed every 12 months.

AIDS Counseling: One pre-counseling and one post-counseling session (state-unique code 9020M) are allowed per client. [Refer to WAC 388-531-0600]

Detox: Three-day alcohol detox and/or five-day drug detox services (state-unique codes 0025M and 0026M) are provided only in an MAA-enrolled hospital based detoxification center. Use the appropriate ICD-9-CM diagnosis code and appropriate detox provider number.
[Refer to WAC 388-531-1650]

Note: Bill MAA directly for managed care clients.

Heart Catheterization: Use modifier 26 (professional component) when billing CPT codes 93501-93533, as heart catheterization are reimbursed only if performed in a hospital setting, except in the case of special agreements.

Needle (Electromyography) EMGs: MAA has adopted CMS established limits for billing needle EMGs, CPT codes 95860 through 95870. The limits are as follows:

Code	Description	Limits
95860 95861 95863 95864	Needle EMG one extremity; With or without related paraspinal areas Two extremities with or without… Three extremities with or without… Four extremities with or without…	• For these to pay, extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95869	Needle EMG; thoracic paraspinal muscles;	• May be billed alone—for thoracic spine studies only • Limited to one unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied, it is not payable separately.
95870	Needle EMG; other than paraspinal muscles (e.g. abdomen or thorax)	• Limited to one unit per extremity *and* one unit for cervical or lumbar paraspinal muscles regardless of number of levels tested (five units maximum payable). • Not payable with extremity codes (CPT codes 95860-95864).

Medical justification to bill for the EMGs must be maintained in the client's file.

Cochlear Implant Services [Refer to WAC 388-531-0200(4)(c)]

MAA's policy regarding cochlear implant services is as follows:

- CPT code 69930, cochlear implants, requires prior authorization (refer to Section I - Authorization). Providers need to send in all medical information explaining why the client needs cochlear implants. In particular, MAA needs information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses physicians for replacement parts for cochlear implants given directly to the client using the HCPCS code A9900. Prior authorization is required for the replacement parts and will be manually price by the authorization department.

- The procedure can be performed in an inpatient hospital setting, outpatient hospital setting or in an Ambulatory Surgery Center (ASC).

- Hospitals must bill the appropriate DRG. The cochlear device and new or refurbished replacement parts are included in the DRG.

- Outpatient hospitals must bill revenue code 278 and attach an invoice for the cochlear device and new or refurbished replacement parts. Reimbursement is through ratio of costs to charges (RCC).

- Ambulatory Surgery Centers (ASCs) must use procedure code L8614 for the cochlear device. ASCs must use HCPCS code L8619 for new replacement parts, and HCPCS code A9900 only for refurbished replacement parts. Enter "refurbished speech processor" in field 19 on the HCFA-1500 claim form or in the Remarks/Comments field for direct entry, magnetic tape or EMC.

Acute Physical Medicine and Rehabilitation (PM&R)

- Inpatient physical medicine and rehabilitation (PM&R) is limited to MAA-contracted facilities. Call 1-800-634-1398.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

MAA's policy regarding VNS is as follows:

- VNS CPT codes 61885, 61886, 61888, 64573, and 64585 require prior authorization (refer to Section I - Authorization).
- The procedures can be performed in an inpatient hospital or outpatient hospital setting.
- Hospitals must bill the appropriate DRG. The VNS implant is included in the DRG.
- Outpatient hospitals must bill revenue code 278 and attach an invoice for the VNS implant. Reimbursement is through ratio of costs to charges (RCC).
- Prior authorization is **not required** for programming CPT codes 95970, 95974, and 95975 performed by the neurologist.

Osseointegrated Implants

Retroactive to dates of service on or after January 1, 2001:

- CPT codes 69714-69718 require prior authorization (refer to Section I – Authorizations).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.
- Hospitals must bill the approprate DRG. The osseointegrated implant is included in the DRG.
- Outpatient hospitals must bill revenue code 278 and attach an invoice for the osseointegrated implant. Reimbursement is through a ration of cost to charges (RCC).

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Sterilizations

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing (this includes vasectomies).

> **Note:** MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to page H15, Hysterectomies.

When does MAA reimburse for sterilization?

[Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent (see page 1, Definitions) in accordance with all of the requirements defined under this Sterilizations section;
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

> **Note: MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.**

Why do I need a DSHS-approved consent form?

Federal regulations prohibit payment for sterilization procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists and assistant surgeons must obtain a copy of a completed consent form to attach to their claim. **No other form will be accepted**. The consent form may be obtained from the physician who performs the sterilization. MAA will deny a claim for a sterilization procedure received without a consent form. MAA will either return or deny a claim with an incomplete or improperly completed consent form.

The claim and completed consent form are to be submitted to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

Consent Form Requirements:

- ✓ The signatures and other information on the consent form must be legible.
- ✓ All blanks on the consent form must be completed except race, ethnicity, and interpreter's statement blanks.
- ✓ For sterilization of a client between 18 and 20 years of age, use the DSHS 13-364(x) Consent Form.

  Cross out age 21 in the following three placed on the form and write in **18**.

  - ➢ *Consent to Sterilization* section, **"I am at least 21..."**
  - ➢ *Statement of Person Obtaining Consent* section, **"To the best of my knowledge....is at least 21..."**
  - ➢ *Physician's Statement* section, **"To the best of my knowledge...is a least 21..."**

What if the physician who signs the consent form is not the physician who performs the sterilization?

The physician identified in the "Consent to Sterilization" section of DSHS 13-364x must be the same physician who completes the "Physician's Statement" section and performs the sterilization procedure. If the physician who signed the above referenced sections of the DSHS 13-364x Consent Form is not the physician performing the sterilization procedure, the client must sign and date a new Consent Form indicating the name of the physician performing the operation under the "Consent for Sterilization" section, at the time of the procedure. This amended consent must be attached to the initial DSHS 13-364(x) Consent Form before billing MAA. **Note: Both consent forms must be attached to each billing. The original consent must meet all of the consent requirements.**

Sample Completed Consent Forms:

See page H5 for a **REGULAR** consent form, page H8/H9 for a **AMENDED** consent form, and page H11 for a **BLANK** consent form. The blank consent form may be photocopied for your use.

To obtain a Consent Form (DSHS 13-364(x)), write or fax your request to:

DSHS Warehouse
PO Box 45816
Olympia, WA 98504-5816
FAX (360) 664-0597

When does MAA waive the 30-day waiting period?

[WAC 388-531-1550(3)(4)]

MAA **does not require** the 30-day waiting period, **but does require** at least a 72-hour waiting period for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the expected date of delivery. The expected date of delivery must be documented on the consent form.

- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

MAA waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a sterilization consent form when one of the following circumstances apply:

- The client became eligible for Medical Assistance during the last month of pregnancy *("NOT ELIGIBLE 30 DAYS BEFORE DELIVERY");*

- The client did not obtain medical care until the last month of pregnancy *("NO MEDICAL CARE 30 DAYS BEFORE DELIVERY")*; or

- The client was a substance abuser during pregnancy, but it not using alcohol or illegal drugs at the time of delivery. *("NO SUBSTANCE ABUSE AT TIME OF DELIVERY.")*

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver conditions has been met. Required language is shown in parenthesis. Electronic billers must indicate this information in the *Comments* field.

When does MAA not accept informed consent?

[Refer to WAC 388-531-1550(5)(6)]

MAA does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

MAA has certain additional consent requirements that the provider must meet before MAA reimburses sterilization of a mentally incompetent or institutionalized client. MAA requires both of the following:

- A court order; and
- A sterilization consent form signed by the legal guardian, sent to MAA.

Reimbursement for Sterilization

MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

MAA reimburses epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.
- The provider cannot bill separately for the BAUs for the sterilization procedure.

How to Complete the Sterilization Consent Form

The following numbers correlate to those listed on the following sample of the Sterilization Consent Form.

Consent to Sterlization

1 Doctor or Clinic – May be different than performing doctor if another physician takes over.
2 Procedure – Type of sterilization or vasectomy
3 Birthday of Client (Month, Day, Year)
4 Client's Name
5 Doctor – Physician that performed surgery, has to be the same name as the physician who signs on bottom right (see #16 below).
6 Procedure – Type of sterilization or vasectomy
7 Signature – Client's signature and dated 30 days prior to surgery date

Statement of Person Obtaining Consent

8 Name of Individual – Patient name
9 Procedure – Type of sterilization or vasectomy
10 Signature of person obtaining consent and dated
11 Facility – Clinic or office name
12 Address – Physical address of clinic or office, city, state and zip code

Physician's Statement

13 Name: Individual to be sterilized – Client's name
14 Date: Sterilization Operation – Date of Service of sterilization
15 Specify type of operation – Name of procedure
16 Physician – Signature of doctor who performed the surgery and dated after, or not more than one week before, the surgery is performed and must be the same physician as #5 above. If not, the addendum consent form must be attached to original consent containing the client signature, date and name of doctor who performed the sterilization.

REGULAR SAMPLE STERILIZATION CONSENT FORM

How to Complete the Amended Consent Form

The following numbers correlate to those listed on the sample Amended Consent Form.

Consent to Sterlization

4 Client's name
5 Doctor or physician that performed surgery (same name as in 16).
7 Signature – Client's signature and current date.

Physician's Statement

13 Name: Individual to be sterilized – Client's name
14 Date: Sterilization Operation – Date of Service of sterilization
15 Specify type of operation – Name of procedure
16 Physician – Signature of doctor who performed the surgery and dated after, or not more than one week before, the surgery is performed.

The next two pages are samples for:

Instances when the physician who performs the surgery is different from the physician who signed the original consent form.

Original and amended consent forms must be stapled together and submitted with each claim.

MODIFIED CONSENT FORM - A

Modified Consent Form – B

Back of Modified Consent Form

Blank Consent Form

Back of Blank Consent Form

Hysterectomies

[Refer to WAC 388-531-1550(10)]

- Hysterectomy will be reimbursed only for medical reasons unrelated to sterilization.
- Prior authorization is not required in either of the following circumstances:
  - ✓ The client has been diagnosed with cancer(s) of the female reproductive organs; and/or
  - ✓ The client is 46 years of age or older.
- Use MAA's expedited prior authorization process for clients 45 years of age and younger who have not been diagnosed with cancer(s) of the female reproductive organs. See Section I - Authorizations.
- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists and assistant surgeons must obtain a copy of a completed DSHS-approved consent form to attach to their claim.
- Claims for a hysterectomy procedure without a DSHS-approved consent forms will be denied.
- A claim with an incomplete DSHS-approved consent form will be returned or denied.
- The claim and completed DSHS-approved consent form are to be submitted to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

- A completed sample consent form follows this page. A blank consent form, which may be photocopied for your use, follows the sample. Any consent form may be used, but it must contain all the consent requirements listed below:
  - ✓ Client's Name
  - ✓ Reason for hysterectomy
  - ✓ Physician's signature
  - ✓ Client's signature

SAMPLE HYSTERECTOMY FORM...TO BE INCLUDED

Blank Hysterectomy Form

Back of Blank Hysterectomy Form

Authorization

[Refer to WAC 388-531-0200]

Limitation Extensions and Expedited Prior Authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For Example: Therapies are not covered under the Medically Indigent Program (MIP).

MAA's authorization requirements can be met by using the following authorization processes:

1. Written or fax authorization; and
2. Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state care is not covered (see page A2). Out of state hospital admissions are not covered unless they are emergency admissions.

Limitation Extensions (LE)

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

Some LE authorizations may be obtained by using the Expedited Prior Authorization process. Refer to the EPA section (page I6) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax authorization process (see below).

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is a paper authorization process available to providers when expedited prior authorization has not been established or the expedited prior authorization criteria is not applicable.

Which services require written/fax authorization?

All services noted in WAC and billing instructions as needing prior authorization require written or fax authorization.

Examples of services that require written/fax authorizations are:

- All PET Scans (HCPCS codes G0030-G0047, G0125, G0210-G0230 and CPT codes 78608-78609, 78459, 78491-78492, 78810)
- Inpatient Acute Physical Medicine and Rehabilitation (CPT codes 99221-99223)
- Cochlear Implantation (CPT code 66930) and Cochlear Implant External Replacement Parts (HCPCs code A9900)
- Cryosurgical Ablation of the Prostate (CPT code 55873)
- Vagus Nerve Stimulator Insertion (CPT codes 61885, 61886, 64573 and 64585)
- Osteointegrated Implants (CPT codes 69714-69718)
- Central Nervous System Assessment/Test (CPT codes 96100, 96110, 96111, 96115, and 96117). Neuropsychological testing is restricted to providers who have a contract with MAA to provide the specific services, and are limited to 12 sessions, per client, per lifetime.
- Services that have published EPA criteria
    - ✓ Only when the client's situation does not meet MAA's published EPA criteria, the service is medically necessary, and there is no option to create an EPA number that indicates the medical necessity is documented in the medical record.

How do I obtain written/fax authorization?

Send or fax your request to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

Fax\Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# ____-____-____

ie (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

_____

Procedure Code _____ Number units requested _____ number units used this year _____

Medical Information

Dates of injury or illness _____

Diagnosis code _____ Diagnosis name _____

Place of service _____

How will approving this request change the course of treatment?

_____

_____

Goal of treatment? _____

_____

_____

What is the clinical justification for this request (if not addressed above?)

_____

_____

_____

Please send in any necessary additional documentation with your request to:

Fax: **360-586-2262** or mail to: Medical Request Coordinator
MAA\DMM (previously DHSQS)
PO Box 45506
Olympia, WA 98504-5506

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state care is not covered (see page A2). Out-of-state hospital admissions are not covered unless they are emergency admissions.

What is the EPA process?

MAA's EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling provider to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all expedited prior authorization numbers, **303** = last three digits of an EPA number, and they indicate both the diagnostic condition, procedure, or service and indicate which criteria the case meets).

Note: When the client's situation does not meet published criteria and there is no option to create an EPA number that indicates the medical necessity is documented in the client's medical record, prior authorization is necessary.

If there is an option to create an EPA number based on the medical necessity being documented in the medical record, and medical necessity can not be documented, the service is not covered.

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request. When care is received in the hospital, the documentation of how the expedited prior authorization criteria was met must also be in the hospital record.

Which services require EPA?

EPA is required for services noted in MAA's billing instructions and WAC as needing expedited prior authorization. Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58550, 58551, 58150-58285, 59525)
  Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

  Exceptions: MAA does not require EPA for clients 46 years of age and older; **and/or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, 239.5).

- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
  Note: Bladder repairs are only allowed for client's with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)

- **Reduction Mammoplasties** (CPT: 19318)
  Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Mastectomies for Gynecomastia** (CPT: 19140)
  Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
  When in excess of MAA establish limitations.

- **Blepharoplasties and Strabismus Surgery**
  Clients 18 years of age and older.

- **Physical and Occupational Therapy**
  When in excess of MAA establish limitations.

See next page for more…

- **Outpatient MRIs and MRAs**

- **Inpatient Medical Admits** (CPT: 99221-99223)
  Note: MAA requires EPA when the diagnosis is in the following chart and the client is seven years of age and older:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789-789.09
Back Pain	724-724.6, 724.8-724.9, 846-847.9
Cellulitis	681-681.9, 682, 682.2-682.9
Chronic pancreatitis	577-577.1
Constipation	560.3, 560.39, 564-564.9
Dehydration; Disorders of Electrolyte Imbalance	276-276.6, 276.8-276.9
Headache	784.0
Gastritis/Gastroenteritis	535-535.6, 558-558.9
Migraine Headache	346-346.9
Nausea/vomiting	536.2; 787-787.03
Malaise & Fatigue	780.7-780.79
Painful Respiration	786.52
Related general symptoms	780, 780.4, & 780.9
Respiratory abnormality	786.09

Short stay admissions (less than 24 hours) do not require authorization – use CPT codes 99218-99220 for admits, and 99217 for discharge.

Clients six years of age and younger do not require prior authorization for inpatient medical admits.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria
Abdominal Hysterectomy	
CPT: 58150, 58180, 58200, 58210	
101	Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions: 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months. 2) Documented hct of <30 or hgb <10 3) Documented failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.
102	Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older: 1) Myomata associated with uterus greater than 12 weeks or 10cm in size 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
103	Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following: 1) Significant findings per laproscope and 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
104	Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics

Code	Criteria
Vaginal Hysterectomy	
CPT: 58270-58285, 58550-58551, 58260-58263	
111	Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions: 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months. 2) Documented hct of less than 30 or hgb less than 10. 3) Documentation of failure of conservative care, i.e.: d&c, laparoscopy, or hormone therapy for at least three months.
112	Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older: 1) Myomata associated with uterus greater than 12 weeks or 10cm in size 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct less than 30 or hgb less than 10 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
113	Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following: 1) Significant findings per laproscope; and 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
114	Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

Code	Criteria	Code	Criteria

115 Diagnosis of **symptomatic pelvic relaxation** (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).

Bladder Neck Suspension

CPT: 51840-51845, 57288-57289

201 Diagnosis of **stress urinary incontinence** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; and
2) Surgically sterile or past child bearing years; and
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; and
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck and
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

Hysterectomy With Colopourethrocystopexy

CPT: 51925, 58152, and 58267

221 Diagnosis of **Abnormal uterine bleeding and Stress Urinary Incontinence**-meeting criteria 101 or 111 and 201 as above.

222 Diagnosis of **Fibroids and Stress Urinary Incontinence**-meeting criteria 102 or 112 and 201 as above.

223 Diagnosis of **Symptomatic Endometriosis and Stress Urinary Incontinence**-meeting criteria 103 or 113 and 201 as above.

224 Diagnosis of **Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence -** meeting criteria 104 and 114 as above.

225 Diagnosis of **Symptomatic Pelvic Relaxation and Stress Urinary Incontinence -** meeting criteria 115 and 201 as above.

226 **Hysterectomy not requiring authorization** (see page 6) and **Stress Urinary Incontinence** meeting criteria 201 as above.

Other Hysterectomies and/or Bladder Repairs With Diagnosis Of 625.6 Or 788.3

CPT: 58150, 58180, 58200, 58210, 58240, 51840-51845, 57288-57289, 51925, 58152, 58550, 58260-58263, 58267, 58270, 58276, 58280, 58285, and 59525

230 Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Reduction Mammoplasties/ Mastectomy For Gynecomastia

CPT: 19318, 19140

241 Diagnosis for **hypertrophy of the breast** with:

1) Photographs in client's chart, and
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, and
   b) Conservative treatment not effective; and
3) Abnormally large breasts in relation to body size with shoulder grooves, and
4) Within 20% of ideal body weight, and
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in clients' chart, and
2) Persistent tenderness and pain, and
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Code	Criteria

Other Reduction Mammoplasties/ Mastectomy For Gynecomastia With Diagnosis Of 611.1 Or 611.9

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Brain Magnetic Resonance Imaging (MRI)
CPT: 70544-70546, 70551-70553

301 Suspected diagnosis of **acoustic neuroma** if one of the following:

1) Unilateral sensorineural hearing loss per audiogram, or
2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation, or
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

302 Suspected diagnosis of **pituitary tumor** with any two of the following:

1) Galactorhea
2) Pre menopausal amenorrhea
3) Elevated prolactin level **(females must have negative pregnancy test)**
4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition

303 Suspected diagnosis of **brain tumor** with any one of the following:

1) Unexplained new onset seizure
2) Objective evidence of increased intracranial pressure
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above

304 **Follow up** of **brain tumor** if done at:

1) Three months from the date of last MRI and in the first two years of diagnosis in any of the following cases:
   a) Tumor is currently being treated
   b) Post treatment
   c) With documented changes in tumor size or
2) Six months from the date of last MRI and in the second to fifth years of diagnosis or
3) One year from the date of last MRI in the sixth to tenth year of diagnosis or
4) Symptoms of recurrence in a client that would be treated aggressively

305 Suspected diagnosis of **multiple sclerosis** with three or more of the following objective findings:

1) Progressive weakness or decreased sensation in extremities
2) Difficulty word finding
3) Diplopia
4) Vertigo or vertigo nystagmus
5) Optic neuritis
6) Facial weakness
7) Positive Lhermitte's sign

Note to 305: Only for initial diagnosis, not as a follow-up.

306 Suspected diagnosis of **toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy** in an HIV positive client with:

1) Central nervous system changes **in a client that would be aggressively treated**.
2) Positive or inconclusive computed tomography with a need for clearer definition **in a client that would be aggressively treated**

307 Diagnosis of **breast cancer** for staging as part of PSCT or BMT protocol.

Code	Criteria
308	Suspected diagnosis of **seizure disorder** with unexplained onset of seizures.
309	Diagnostic evidence of **refractory seizures**, as part of preoperative work up.
390	MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Lumbar MRI

CPT: 72148, 72149, 72158

Code	Criteria
311	Suspected diagnosis of **Herniated Nucleus Pulposus or Tumor** in a surgical candidate with two or more of the following objective findings: 1) New onset of bowel or bladder incontinence not related to known diagnosis 2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles) 3) Visible atrophy of key muscle groups of lower extremities 4) Decrease sensation in a dermatomal pattern not previously attributed to another diagnosis 5) Significant weakness of key muscle groups of either or both lower extremity 6) Positive study indicating definitive nerve root compression
312	Suspected diagnosis of **tumor or abscess** with a bone scan or xray suspicious for same.
390	MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Cervical MRI

CPT: 72141, 72142, 72156

Code	Criteria
321	Suspected **herniated nucleus pulposa or tumor** with two or more of the following objective findings: 1) Decreased tricep, bicep, or brachial radialis reflex 2) Decrease sensation in upper extremities in a dermatomal distribution 3) Decreased muscle strength of upper extremities and limitation of movement 4) Upper extremity muscle atrophy 5) Hyperreflexia 6) Positive babinski in non infant 7) Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome
Note to 321:	**Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.**
322	Suspected diagnosis of **tumor or abscess** with a bone scan or xray suspicious for same.
390	MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Thoracic MRI

CPT: 72146, 72147, 72157

Code	Criteria
331	Suspected diagnosis of **tumor or abscess**: 1) With a bone scan or xray suspicious for same, or 2) Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.
390	MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Code	Criteria

Pelvic MRI
CPT: 72195-72197

341 Suspected diagnosis of **avascular necrosis** with:

1) Pain in the hip radiating to the knee and
2) A history of one of the following:
   a) Previous trauma
   b) Intracapsular fractures
   c) Alcoholism
   d) High dose steroid use
   e) Air embolism from diving, or
   f) Hemoglobinopathies

342 Suspected diagnosis of **tumor or abscess** with a bone scan or xray suspicious for same

390 MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Knee MRI
CPT: 73721

351 Suspected **anterior cruciate ligament tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least three of the following:

1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling, or
2) Four or more weeks of conservative care, or
3) Current exam with the following findings: hemarthrosis and\or positive Lockman's and\or positive pivot shift, or
4) MRI is necessary to choose treatment option(s).

352 Suspected **posterior cruciate ligament tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of direct blow to anterior tibia or forced hyperflexion, or
2) Four or more weeks of conservative care, or
3) Current clinical with one or more positive findings: positive drawers, test positive tibial sag.

353 Suspected **meniscal tear** when xray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of twisting injury with subsequent catching, locking, and swelling, or
2) Four or more weeks of conservative care, or
3) One or more of the following exam findings: joint line tenderness, positive McMurrays.

390 MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Upper Extremity MRI
CPT: 73218-73223

361 Suspected diagnosis of **tumor or abscess** with a bone scan or xray suspicious for same.

390 MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Code	Criteria

Lower Extremity MRI
CPT: 73718-73723

371 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

390 MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Abdominal MRI
CPT: 74181-74183

381 Suspected diagnosis of **tumor or abscess** with both of the following:

1) Ultrasound positive for mass on the kidney, pancreas, or liver, and
2) Objective evidence of poor renal function.

390 MRIs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Other MRI/MRA
CPT: 70336, 70540-70543, 70547-70549, 71550, 71555, 72198, 73225, 73725, 74185, 75552-75556, 76093-76094, and 76400

390 MRIs/MRAs not meeting expedited criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Note: If billing for more than one MRI/MRA for the same reason, use criteria code 390.

Note: If billing for more than one MRI/MRA for different reasons, build two separate expedited prior authorization numbers.

Code	Criteria

Medical Admits
CPT: 99221-99223

401 Diagnosis of **Cellulitis** (681-681.9, 682, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any one of the following:

1) Incision & drainage during admit, or
2) White Count greater than10 on admit, or
3) Persistence or progression of fever, lymphodenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

402 Diagnosis of **Abdominal Pain** (789-789.09) in a client with a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours.

403 Diagnosis of **Dehydration or Electrolyte Imbalances** (276-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.

404 Diagnosis of **Nausea/Vomiting** (536.2; 787-787.03) in a client:

1) With a Nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or
2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours

405 Diagnosis of **Gastritis** (535-535.6, 558-558.9) in a client:

1) With a Nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours, or
2) That is unable to tolerate PO and is treated with Intravenous medications, during the hospital stay, for greater than 30 hours.

Code	Criteria

406 Diagnosis of **headaches** (784.0**,** 346-346.9) in a client receiving Intravenous DHE, during the hospital stay, for greater than 30 hours.

407 Diagnosis of **chronic pancreatitis** (577, 577.1) in a client:

1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; or
2) That is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.

408 Diagnosis of **back pain** (724-724.5, 724.8-724.9, 846-847.9) in a client:

1) Failed outpatient treatment; and
2) Continued use of IV pain medication, during the hospital stay, greater than 30 hours; or
3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.

409 Diagnosis of **constipation** (560.3, 560.39, 564-564.9) in a client:

1) Failed outpatient treatment; or
2) Recent abdominal surgery; and
3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.

Other Medical Admits

420 Medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary for continued stay over 24 hours. Medical necessity must be clearly evident by the documentation in the client's medical record.

Diagnosis of **related general symptoms** (780, 780.4, 780.9)
Diagnosis of **respiratory abnormality** (786.09)
Diagnosis of **malaise and fatigue** (780.7)
Diagnosis of **painful respiration** (786.52)

Code	Criteria

Visual Exams
CPT: 92014-92015

610 **Eye Exam** within two (2) years of last exam when no medical indication exists and **both** of the following are documented in the client's record:

1) Glasses or contacts are broken or lost; **and**
2) Last exam was 18 months ago or longer.

Dispensing\Fitting Fees For Glasses
CPT: 92340-92342

615 **Glasses (both frames and lenses)** within two (2) years of last dispense may be replaced when glasses are broken or lost and **all** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Both frames and lenses are broken or lost.

Dispensing\Fitting Fees For Frames Only
CPT: 92340

618 **Frames Only** within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record:

1) No longer covered under the manufacturer's one (1) year warranty; **and**
2) Copy of current prescription demonstrating the need for prescription eye wear; **and**
3) Documentation of frame damage.

Code	Criteria	Code	Criteria

619 **Durable Frames (American Athletic or Invincible)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

620 **Flexible Frame (Daryl or Scott)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

Dispensing|Fitting Fees For Lenses Only
CPT: 92341, 94342

623 **Lenses Only** within two (2) years of last dispense when the lenses only are lost or broken and **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Documentation of lens damage or loss.

624 **Lenses Only** within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lenses at no charge) when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) The current exam shows a refractive change of .75 diopters or more; **and**
4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; **and**
5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy).

Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lenses are allowed when (1)-(4) previously listed are true.

625 **High Index Lenses** when **one** of the following is documented in the client's record:

1) Spherical correction is greater than, or equal to, +\- 8 diopters; **or**
2) Cylinder correction is greater than, or equal, to +\- 3 diopters.

626 **Executive bifocals and trifocals** for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.

Dispensing|Fitting Fees For Contacts
STATE-UNIQUE CODES: 9275M, 9276M, or 9277M

627 **Contacts (client must meet criteria found in the Optometrist Billing Instructions for contacts)** within one (1) year of last dispense may be replaced when contacts are broken or lost and **both** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months) **and**
2) Date of last dispense documented.

Code	Criteria	Code	Criteria

Blepharoplasties
CPT: 67901-67924

630 Blepharoplasty for noncosmetic reasons when both of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and
2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Strabismus Surgery
CPT: 67311-67340

631 Strabismus surgery for clients 18 years of age and older when both of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

Physical Therapy
CPT: 97010-97150, 97520-97537,97750

640 **An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has **one** of the following surgeries or injuries:

1) Lower Extremity Joint Surgery;
2) CVA not requiring acute inpatient rehabilitation; or
3) Spine surgery.

641 **An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Occupational Therapy
CPT: 97110, 97112, 97530, 97532-97533

644 **An additional 12 Occupational Therapy** visits when the client has used the allowed visits for the current year and has **one** of the following:

1) Hand\Upper Extremity Joint Surgery; or
2) CVA not requiring acute inpatient rehabilitation.

645 **An additional 24 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650 and WAC 388-531-0700]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require authorizations**. See next page for a list of COEs.

- ✓ Organ/bone marrow/peripheral stem cell transplants;
- ✓ Inpatient Chronic Pain Management (0088M-0099M);
- ✓ Sleep studies (CPT codes 95805, 95807-95811) only allowed for ICD-9 Diagnosis 780.51, 780.53, 780.57, or 347;
- ✓ Weight Loss Program.

Note: When billing hard copy, note the COE in Box 32 on the HCFA-1500 claim form or in the *Comments* field when billing electronically.

MAA APPROVED ORGAN TRANSPLANT*
CENTERS OF EXCELLENCE (COE)

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	• Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 47135-47136 • 50360, 50365, 50380
Fred Hutchinson Cancer Research Center/Seattle	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Good Samaritan Hospital Medical/Puyallup	• PSC-T	• 38231, 38240-38241
Inland NW Blood Center	• PSC-T	• 38231, 38240-38241
Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Providence St. Peter Hospital/Olympia	• PSC-T	• 38231, 38240-38241
Oregon Health Sciences University (OHSU)/Portland	• Heart • Liver • Kidney • Pancreas	• 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
Sacred Heart Medical Center/Spokane	• Kidney • Heart • Heart/Lung(s) • Lung	• 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	• BMT • PSC-T	• 38230, 38240-38241 • 38231, 38240-38241
St. Joseph's Hospital/Tacoma	• BMT (autologous only) • PSC-T	• 38230, 38241 • 38231, 38240-38241

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

MAA APPROVED ORGAN TRANSPLANT*
CENTERS OF EXCELLENCE (COE) (cont.)

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	• Kidney • PSC-T	• 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	• BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	• Kidney • Pancreas • BMT • PSC-T	• 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

MAA Approved Sleep Study Centers [Refer to WAC 388-531-1500]
Auburn Regional, Auburn
Children's Hospital & Medical Center, Seattle
Columbia Sleep Lab, Richland; Dr William Scott Klipper
Good Samaritan Hospital & Medical Center, Portland
Good Samaritan Hospital, Puyallup
Highline Sleep Disorder Center, Seattle
Mary Bridge Children's Hospital, Tacoma
Mid-Columbia Medical Center, The Dalles, OR
Providence General Medical Center, Everett
Providence Medical Center, Seattle
Providence Medical Center, Yakima
Providence St. Peter's Hospital, Olympia
Providence Swedish, Seattle
Richland Sleep Laboratory, Richland; Dr. Pat Hamner
Sacred Heart Medical Center, Spokane
St. Clare Hospital, Tacoma
St. Joseph's, Lewiston, ID
St. Mary Medical Center, Walla Walla
Swedish at Ballard-Swedish Sleep Institute/Medical Center, Seattle
Tacoma General Hospital, Tacoma
Valley Medical, Renton
Virginia Mason Medical Center, Seattle

Physicians must:

- Use CPT procedure codes 95805, 95807-95811 for sleep study services.
- Enter the name of the approved hospital or clinic where the sleep study/ polysomnogram or multiple sleep latency testing was performed.
- When billing electronically, enter the information into the *Comments* field. If you are billing hard copy, enter the information in field 32 on the HCFA-1500 claim form.
- All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57**; or Narcolepsy **347**.

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

MAA-Approved Weight Loss Program
MAA encourages any providers who have structured weight loss programs and would like to be included as an MAA approved facility [refer to WAC 388-531-1600] to send their program criteria and credentials to: MAA ATTN: Dr. Joan Baumgartner PO Box 45500 Olympia, WA 98504-5500

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Site of Service (SOS) Payment Differential

How are fees established for the professional services performed in the facility and non-facility settings?

Based on the RBRVS methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components (work, practice expense and malpractice expense). MAA uses the two levels of practice expense to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS MAF) -** Paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS MAF) -** Paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include many:

- Evaluation and management codes, which specify the site of service within the description of the procedure codes; and
- Major surgical procedures that are generally only performed in hospital settings.

How will the site of service payment policy affect provider reimbursements?

Providers billing professional services will be reimbursed at one of two maximum allowable fees, depending on where the service is performed.

Does MAA reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments, one to the performing provider and another to the facility. The reimbursement to the facility includes the payment for resources. The NFS MAF includes the allowance for resources.

The professional FS MAF excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower FS MAF to performing providers when the facility is also reimbursed eliminates duplicate payment for resources.

When are professional services reimbursed at the Facility Setting Maximum Allowable Fee?

Providers are reimbursed at the FS MAF when MAA also makes a payment to a facility. MAA will follow CMS's determination for using the FS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the FS MAF:

MAA Place of Service Code	CMS Place of Service Description
1	Inpatient Hospital
2	Outpatient Hospital
5	Emergency Room- Hospital
6	Ambulatory Surgery Center
8	Skilled Nursing Facility
8	Nursing Facility
2	Hospice
1	Inpatient Psychiatric Facility
2	Psychiatric Facility Partial Hospitalization
7	Intermediate Care Facility/Mentally Retarded
1	Comprehensive Inpatient Rehabilitation Facility
2	Comprehensive Outpatient Rehabilitation Facility
2	End-Stage Renal Disease Treatment Facility

Due to Medicare consolidated billing requirements, MAA does not make a separate payment to providers who perform certain services in hospitals and skilled nursing facilities. The facilities will be reimbursed at the NFS MAF. Some therapies, such as physical therapy services (Current Procedural Terminology (CPT) 97001-97799), will always be paid at the NFS MAF.

When are professional services reimbursed at the Non-Facility Setting Maximum Allowable Fee?

The NFS MAF is paid when MAA does not make a separate payment to a facility. Services performed in a provider's office, client's home, facility or institution (listed in the following table) will be reimbursed at the NFS MAF. MAA will follow CMS's determination for using the NFS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the NFS MAF:

MAA Place of Service Code	CMS Place of Service Description
3	Office *
4	Home
9	Birthing Center
9	Military Treatment Facility
9	Custodial Care Facility
9	Adult Living Care Facility
3	Federally Qualified Health Center
3	Community Mental Health Center
9	Residential Substance Abuse Treatment Facility
9	Psychiatric Residential Treatment Center
3	State or Local Public Health Clinic
3	Rural Health Clinic
3	Independent Laboratory
9	Other Unlisted Facility

*Includes Neurodevelomental Centers

What professional services have an SOS payment differential?

Most of the services with an SOS payment differential are from the surgery, medicine and evaluation and management ranges of CPT. However, some HCPCS, CPT radiology, pathology and laboratory codes also have an SOS payment differential.

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State-Unique and Selected HCPCS Procedure Codes

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
Developmental Disabilities Program		
0310M	Annual physical exam (Use diagnosis code V93.0.)	$102.45
Tuberculosis Treatment Services		
9011M	Initial TB examination	$35.34
9012M	Follow-up TB examination	$21.05
AIDS Counseling Services		
9020M	Risk factor reduction intervention for HIV/AIDS clients only one precounseling session and one postcounseling session (Use diagnosis code V65.9 if lab test results are negative.)	$27.22
Detox		
0025M	Detox - hospital admit	$41.46
0026M	Detox - hospital follow-up	$20.84
EPSDT		
0252M	Interperiodic screening	$18.42
Indwelling Catheter		
G0002	Office procedure, insertion temporary indwelling catheter, Foley type (Not allowed if performed on the same day as or during the postoperative period of a major surgery.)	
	Non Facility Setting	$66.78
	Facility Setting	$18.82

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
Anesthesia		
5911M	Vasectomies Use when CPT codes 54690, 55250, and 55450 are billed	Base 3.0
5912M	Sterilizations Use when CPT codes 58600, 58605, 58611, 58615, 58670 and 58671 are billed	Base 6.0
5913M	Hysterectomies Use when billing CPT codes 51925, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550 and 59135 are billed	Base 6.0
5914M	Hysterectomies Use when billing CPT codes 58200, 58210, 58240, 58285 and 59525 are billed	Base 8.0
5915M	Abortions Use when billing CPT codes 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857 are billed	Base 3.0
CPT 01953	Anesth, burn, each 9 percent	$15.49
CPT 01996	Manage daily drug therapy	$20.84
Dental Anesthesia		
State-unique code 0100M has been discontinued effective 7/1/01. Please use CPT code 00170.		

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Cast Materials Only - Plaster or Fiberglass

The reimbursement for cast materials is now based on the size and number of rolls used in preparing a cast instead of the type of cast prepared. The maximum allowable fees are for the cost of one roll and whether the cast was fiberglass or plaster. When billing, use the procedure code for the size of rolls and the number of each used. Below are the procedure codes that should be used when billing for cast materials:

State Unique Code 2999M has been deleted. Use CPT code 29580.

2978M	Fiberglass, 2" x 4 yd roll	$9.75
2979M	Fiberglass, 3" x 4 yd roll	$12.50
2980M	Fiberglass, 4" x 4 yd roll	$16.00
2981M	Fiberglass, 5" x 4 yd roll	$18.50
2982M	Plaster, 2" x 3 yd roll	$1.35
2983M	Plaster, 3" x 3 yd roll	$1.75
2984M	Plaster, 4" x 5 yd roll	$2.65
2985M	Plaster, 5" x 5 yd roll	$2.90
2986M	Plaster, 6" x 5 yd roll	$3.50
2987M	Plaster, 8" x 5 yd roll	$4.05

Maternity Care And Delivery

5930M	Initial prenatal assessment; includes medical history, physical examination, and identification of risk factors	$50.00
5941M	High-risk vaginal delivery, add-on fee (to be used by delivering physician only)	$278.43
5935M	Labor management	$278.43
5947M	Antepartum and postpartum care and assist at cesarean section **(do not use modifier 80)**	$1,021.88
5951M	Routine antipartum care, first and second trimester, per month	$73.00
5952M	Routine antepartum care, third trimester, per month	$124.23
5953M	High-risk management, first trimester, add-on, per month	$30.38
5954M	High-risk management, second trimester, add-on, per month	$37.63
5955M	High-risk management, third trimester, add-on, per month	$90.68

Note: Bill one unit per calendar month. Use a separate detail line for each calendar month, indicating the date of service. If you perform total obstetrical care including antepartum, delivery and post-partum, bill one of the global obstetric codes.

5959M	High-risk cesarean section, add-on fee	$278.43

Radiology

7612M	Transportation and set-up of portable radiologic equipment; at bedside or in operating room, not otherwise specified (**Included in DRG for inpatient services. Outpatient services are payable by special agreement only.)**	$8.61
7698M	Transportation and set-up of portable equipment; ultrasound, bedside or in operating room **(Included in DRG for inpatient services. Outpatient services are paid by special agreement only.)** For each additional patient, use R0075.	B.R.
G0173	Stereotactic radiosurgery, complete course of therapy in one session	B.R.
G0174	Intensity modulated radiation therapy (IMRT) plan, per session	B.R.
G0178	Intensity modulated radiation therapy (IMRT) delivery to multiple areas with treatement setup and verification images	B.R.

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
R0070	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; one patient seen.	$43.04
R0075	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; more than one patient seen, per patient	$13.98
R0076	Transportation of portable EKG to facility or location, per patient (payable only with 93000 or 93005)	Bundled
Cancer Screening		
G0101	Cervical or vaginal cancer screening, pelvic and clinical breast examination	
	Non Facility Setting	$23.08
	Facility Setting	$14.57
G0103	Prostate cancer screening Prostate specific antigen test (PSA) total	$18.30
G0104	Colorectal cancer screening; flexible sigmoidoscopy	
	Non Facility Setting	$57.82
	Facility Setting	$30.70
G0105	colonoscopy on individual at high risk	
	Non Facility Setting	$222.53
	Facility Setting	$138.94
G0106	alternative to G0104, screening sigmoidoscopy, barium enema	$84.04
	modifier 26 (professional)	$31.37
	modifier TC (technical)	$52.66
G0107	Colorectal cancer screening; fecal occult blood test, 1-3 simultaneous determinations	$3.23
G0120	alternative to G0105, screening colonoscopy, barium enema	$84.03
	modifier 26 (professional)	$31.37
	modifier TC (technical)	$52.66
G0121	colonoscopy on individual not meeting criteria for high risk	
	Non Facility Setting	$222.53
	Facility Setting	$138.94
G0122	barium enema	$84.71
	modifier 26 (professional)	$32.05
	modifier TC (technical)	$52.66
G0130	Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton peripheral (e.g., radius, wrist, heel)	$26.22
	modifier 26 (professional)	$7.62
	modifier TC (technical)	$18.60
G0131	Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)	$80.00
	modifier 26 (professional)	$8.74
	modifier TC (technical)	$71.26
G0132	Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	$26.22
	modifier 26 (professional)	$7.62
	modifier TC (technical)	$18.60
Pathology/Laboratory		
G0026	Fecal leukocyte examination	$4.25
G0050	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound	$20.17

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
Laboratory		
P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision.	$14.60
P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by a physician.	$14.57
P9612	Catheterization for collection of specimen, single patient	$2.41
Q0111	Wet mount	$4.25
Q0112	Potassium hydroxide	$4.25
Q0113	Pinworm examination	$5.38
Q0114	Fern test	$7.11
	specimen(s) (urine) single patient, all place of service.	
Q0115	Post – coital direct, qualitative exam	$9.85
8999M	Virtual phenotype	B.R.
Laboratory Stat		
8949M	Stat	$3.30
Family Contraceptive Management		
J1055	Depro Provera,	$47.65
	150 mg contraceptive injection; allowed once every 65 days.	
1111J	Lunelle, monthly contraceptive injection	$22.21
1112J	Emergency Contraception Pills (ECP)	Acquisition Cost
Psychiatry		
9089M	Certification activities related to elective inpatient psychiatric admission for clients younger than 21 years of age to an inpatient psychiatric facility. Billed by a member of a certification team (e.g., physician, psychiatrist).	$65.72
Lotions		
	Oxsoralen 1% lotion (used for Vitaligo)	Not Covered
Involuntary Treatment Act (ITA)		
9083M	Involuntary Treatment Act physical exam	$35.59
9084M	Involuntary Treatment Act psychiatric admission and evaluation	$92.87
9085M	Involuntary Treatment Act court testimony, under 20 minutes	$19.47
9086M	Involuntary Treatment Act court testimony, 20-50 minutes	$29.53
9087M	Involuntary Treatment Act court testimony, over 50 minutes	$48.69
Ophthalmology		
V2623	Prosthetic eye, plastic, custom	$866.93
V2624	Polishing/resurfacing of ocular prosthesis	$65.41
V2625	Enlargement of ocular prosthesis	$357.66
V2626	Reduction of ocular prosthesis	$214.36
V2627	Scleral cover shell	$1,384.42
V2628	Fabrication and fitting of ocular stent	$326.89
V2630	Anterior chamber intraocular lens	$337.36

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
V2631	Iris supported intraocular lens	$337.36
V2632	Posterior chamber intraocular lens	$337.36
9274M	Materials used for glasses repair (specify materials billed)	$14.95
9275M	Fitting (including dispensing) fee for therapeutic bandage lenses. (**Including 14-day follow-up care.**)	$121.70
9276M	Fitting (including dispensing) fee for contact lenses. (**Including 30-day follow-up care for training period.**)	$45.65
9277M	Fitting of contact lenses for treatment of disease. (**Including 90-day follow-up care.**)	$138.67
G0184	Destruction of localized lesion of choroid; ocular photodynamic therapy, other eye **(Add-on code to CPT 67221)**	$24.20
G0185	transpupillary thermotherapy one or more sessions	B.R.
G0186	photocoagulation, feeder vessel technique (one or more sessions)	B.R.
G0187	Destruction of macular drusen, photocoagulation (one or more sessions)	B.R.
Otorhinolaryngology		
G0193	Endoscopic study of swallowing function (FEES)	B.R.
G0194	Sensory testing during endoscopic study of swallowing (FEEST) **(Add-on Code)**	B.R.
G0195	Clinical evaluation of swallowing Function	Non-facility: $71.71 Facility: $54.01
G0196	Evaluation of swallowing involving swallowing of radio-opaque materials	Non-facility: $71.71 Facility: $54.01
G0197	Evaluation of patient for prescription of speech generating devices	Non-facility: $73.95 Facility: $47.96
G0198	Patient adaptation and training for use of speech generating devices.	Non-facility: $46.16 Facility: $35.41
G0199	Re-evaluation of patient using speech generating devices	Non-facility: $61.85 Facility: $36.08
G0200	Evaluation of patient for prescription of voice prosthetic	Non-facility: $73.95 Facility: $47.96
G0201	Modification or training in use of voice prosthetic	Non-facility: $46.16 Facility: $35.41
Neurology		
9593M	F-wave-auditory brainstem	$28.00
Vestibular Function Test, With Recording (e.g., ENG, PENG, And Medical Diagnostic Evaluation)		
9254M	Electronystamographic testing, complete with recording and interpretation (ENG)	$102.93
Cardiography		
9301M	Computer-simulated ECG with interpretation and report	$12.49
9302M	Transmission and assimilation only	$3.64

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
9303M	Over-reading (interpretation) and report only	$9.14
G0004	Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period; includes transmission, physician review and interpretation	$190.04
G0015	Post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24 hour attended monitoring, per 30-day period; tracing only	$142.75
G0016	Physician review and interpretation	$18.15
Podiatry/Orthotics		
1600L	Single fabricated orthotic	$60.94
1601L	Pair fabricated orthotic	$109.56
1602L	Impression casting, each foot	$43.15
1603L	Prefabricated orthotic (attach invoice if over $50.00)	B.R.
1604L	Impression casting, custom shoes	$150.96
NOTE:	**Orthotic fees include dispensing.** Any other procedure codes for prosthetic/orthotics must be billed using a prosthetic/orthotic provider number.	
Physical Medicine		
0002M	Custom splint (cockup and/or dynamic)	$47.05
Drug-Induced Abortions (RU-486)		
S0190	Mifepristone, oral, 200 mg	Acquisition Cost
S0191	Misoprostol, oral, 200 mcg	Acquisition cost
Norplant/IUD/Diaphragm		
A4260	Levonorgestrel (contraceptive) implants system, including implants & supplies. *One Norplant System allowed in 5 years.*	$451.68
9911M	Intra Uterine Device (IUD) (not copper) (For intrauterine copper contraceptive device, see J7300)	$299.00
9912M	Diaphragm	$45.00
9913M	Mirena IUD	$351.55
A4261	Cervical cap for contraceptive use	$47.00
Surgery		
4693M	Infared coagulation internal hemorrhoids	$106.00
G0168	Wound closure utilizing tissue adhesive(s) only	
	Non Facility Setting	$50.65
	Facility Setting	$15.91
Blood Product Processing For Transfusion		
P9010	Blood (whole), each unit	$54.30
P9011	Blood (split unit), specify amount	B.R.
P9012	Cryoprecipitate, each unit	$25.81
P9016	Leukocyte poor blood, each unit	$44.86
P9017	Plasma, fresh frozen, each unit	$47.11

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
P9019	Platelet concentrate, each unit	B.R.
P9020	Platelets rich plasma, each unit	B.R.
P9021	Red blood cells (RBC), packed cells, each unit	$65.66
P9022	Washed RBC, washed platelets, each unit	$20.20
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	B.R.
P9031	Platelets, leukocytes reduced, each unit	B.R.
P9032	Platelets, irradiated, each unit	B.R.
P9033	Platelets, leukocytes reduced, irradiated, each unit	B.R.
P9034	Platelets, pheresis, each unit	B.R.
P9035	Platelets, pheresis, leukocytes reduced, each unit	B.R.
P9036	Platelets, pheresis, irradiated each unit	B.R.
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	B.R.
P9038	Red blood cells, irradiated, each unit	B.R.
P9039	Red blood cells, deglycerolized each unit	B.R.
P9040	Red blood cells, leukocytes reduced, irradiated, each unit	B.R.
P9041	Infusion, albumin (human), 5%, 50 ml	B.R.
P9042	Infusion, albumin (human), 25%, 10 ml	B.R.
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	B.R.
P9044	Plasma, cryoprecipitate reduced each unit	B.R.

Application of Fluoride Varnish (physician and ARNPS)

0122D	Application of fluoride varnish (Physician and ARNPs). Allowed 3 times in a 12-month period for children 18 years of age and younger.	$18.93

Hyalgan/Synvisc **(See page C17 for policy)**

J7315	Sodium Hyaluronate, 20 mg, for intra-articular injection (Hyalgan) ***Maximum of 5 injections. *One injection = one unit**	$132.20
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc) ***Maximum of 3 injections. *One injection = one unit**	$215.65

Clozaril

0857J	Clozaril case coordination	$10.41

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Bundled Services Not Paid Separately

CPT Code	Description	CPT Code	Description
15850	Removal of sutures	94761	Measure blood oxygen level
20930	Spinal bone allograft	96545	Provide chemotherapy agent
20936	Spinal bone autograft	96902	Trichogram
22841	Insert spine fixation device	97010	Hot or cold packs therapy
43752	Nasal/orogastric w/stent	99000	Specimen handling
59200	Insert cervical dilator	99001	Specimen handling
78890	Nuclear medicine data proc	99002	Device handling
78891	Nuclear med data proc	99024	Post-op follow-up visit
89321	Nasal/orogastric w/stent	99025	Initial surgical evaluation
90885	Psy evaluation of records	99056	Non-office medical services
90887	Consultation with family	99058	Office emergency care
90889	Preparation of report	99071	Patient education materials
92531	Spontaneous nystagmus study	99078	Group health education
92532	Positional nystagmus study	99080	Special reports or forms
92533	Caloric vestibular test	99090	Computer data analysis
92534	Optokinetic nystagmus	99100	Special anesthesia service
93740	Temperature gradient studies	99116	Anesthesia with hypothermia
93740-26	Temperature gradient studies	99135	Special anesthesia procedure
93740-TC	Temperature gradient studies	99140	Emergency anesthesia
93770	Measure venous pressure	99141	Sedation, iv/im or inhalant
93770-26	Measure venous pressure	99142	Sedation, oral/rectal/nasal
93770-TC	Measure venous pressure	99173	Visual acuity screen
94150	Vital capacity test	99358	Prolonged serv, w/o contact
94760	Measure blood oxygen level	99359	Prolonged serv, w/o contact

CPT Code	Description	CPT Code	Description
99374	Home health care supervision		
99377	Hospice care supervision		
99379	Nursing fac care supervision		

HCPCS Codes

G0102	Prostate ca screening; dre
G0008	Admin influenza virus vac
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis b vaccine
R0076	Transport portable EKG

Supplies Included in Office Call (Bundled Supplies)

Note:

*****Items with an asterisk on the following list are considered prosthetics when used for a **permanent** condition. They may be paid for permanent conditions if they are provided in the physician's office. They are not considered prosthetics if the condition is acute or temporary. Please indicate on the claim if billing for a permanent condition.

Examples would be Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed for which the physician was required to replace the Foley, then the catheter would be considered a prosthesis and would be paid separately.

HCPCS Code	Description	HCPCS Code	Description
A4206	Syringe with needle, sterile 1cc	A4245	Alcohol wipes, per box
A4207	Syringe with needle, sterile 2cc	A4246	Betadine or phisohex solution
A4208	Syringe with needle, sterile 3cc	A4247	Betadine or iodine swabs/wipes
A4209	Syringe with needle, sterile 5cc	A4253	Blood glucose test
A4211	Supplies for self-administered injections	A4256	Normal, low and high cal solution
A4212	Huber-type needle, each	A4258	Spring-powered device for lancet, each
A4213	Syringe, sterile, 20 CC or greater	A4259	Lancets, per box
A4214	Sterile saline or water, 30 CC	A4262	Temporary lacrimal duct implant, each
A4215	Needles only, sterile, any size	A4265	Paraffin, per pound
A4220	Refill kit for implantable infusion pump	A4270	Disposable endoscope sheath, each
A4244	Alcohol or peroxide, per pint	A4301	Implantable access total system

HCPCS Code	Description
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4322	Irrigation syringe, bulb or piston
A4323	Sterile saline irrigation solution
A4326*	Male external catheter
A4327*	Female external urinary collection metal cup, each
A4328*	Female external urinary collection pouch, each
A4329*	External catheter starter set
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4347*	Male external catheter
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4359*	Urinary suspensory, without leg bag
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4365*	Ostomy bag, disposable, closed
A4367*	Ostomy belt
A4368*	Stoma wicks, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4454	Tape, all tapes, all sizes
A4455	Adhesive remover or solvent
A4460	Elastic bandage

HCPCS Code	Description
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)
A4649	Surgical supply; miscellaneous
A5051*	Pouch, closed; with barrier
A5052*	Pouch, closed; without barrier
A5053*	Pouch, closed; use on faceplate
A5054*	Pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Pouch, drainable; with barrier
A5062*	Pouch, drainable; without barrier
A5063*	Pouch, drainable; use on barrier
A5064*	Pouch, drainable; with faceplate
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5074*	Pouch, urinary; with faceplate
A5075*	Pouch, urinary; use on faceplate
A5081*	Continent device; plug
A5082*	Continent device; catheter
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary suspensory; with leg bag
A5112*	Urinary leg bag; latex
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5119*	Skin barrier; wipes, box per 50
A5121*	Skin barrier; solid, 6 X 6
A5122*	Skin barrier; solid, 8 X 8
A5123*	Skin barrier; with flange
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6020	Collagen based wound dressing
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
99070 (CPT)	Special supplies

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Office Procedures That Are Billable With Procedure Code A4550

CPT Code	Description	CPT Code	Description
19101	Biopsy of breast; open	45384	Lesion removal colonoscopy
19120	Removal of breast lesion	45385	Lesion removal colonscopy
19125	Excision, breast lesion	49080	Puncture, peritoneal cavity
19126	Excision, addl breast lesion	49081	Removal of abdominal fluid
20200	Muscle, biopsy	52005	Cystoscopy & ureter catheter
20205	Deep muscle biopsy	52007	Cystoscopy and biopsy
20220	Bone biopsy, trocar/needle	52010	Cystoscopy & duct catheter
20225	Bone biopsy, trocar/needle	52204	Cystoscopy
20240	Bone biopsy, excisional	52214	Cystoscopy and treatment
25111	Remove wrist tendon lesion	52224	Cystoscopy and treatment
28290	Correction of bunion	52234	Cystoscopy and treatment
28292	Correction of bunion	52235	Cystoscopy and treatment
28293	Correction of bunion	52240	Cystoscopy and treatment
28294	Correction of bunion	52250	Cystoscopy and radiotracer
28296	Correction of bunion	52260	Cystoscopy and treatment
28297	Correction of bunion	52270	Cystoscopy and revise urethra
28298	Correction of bunion	52275	Cystoscopy & revise urethra
28299	Correction of bunion	52276	Cystoscopy and treatment
32000	Drainage of chest	52277	Cystoscopy and treatment
37609	Temporal artery procedure	52282	Cystoscopy, implant stent
38500	Biopsy/removal, lymph nodes	52283	Cystoscopy and treatment
43200	Esophagus endoscopy	52290	Cystoscopy and treatment
43202	Esophagus endoscopy, biopsy	52300	Cystoscopy and treatment
43220	Esoph endoscopy, dilation	52301	Cystoscopy and treatment
43226	Esoph endoscopy, dilation	52305	Cystoscopy and treatment
43234	Upper GI endoscopy, exam	52310	Cystoscopy and treatment
43235	Upper GI endoscopy, diagnosis	52315	Cystoscopy and treatment
43239	Upper GI endoscopy, biopsy	57520	Conization of cervix
43245	Operative upper GI endoscopy	57522	Conization of cervix
43247	Operative upper GI endoscopy	58120	Dilation and curettage
43249	Esoph endoscopy, dilation	62270	Spinal fluid tap, diagnostic
43250	Upper GI endoscopy/tumor	85095	Bone marrow aspiration
43251	Operative upper GI endoscopy	85102	Bone marrow biopsy
43458	Dilate esophagus	96440	Chemotherapy intracavitary
45378	Diagnostic colonoscopy	96445	Chemotherapy, intracavitary
45379	Colonoscopy w/fb removal	96450	Chemotherapy, into CNS
45380	Colonoscopy and biopsy		
45382	Colonoscopy/control bleeding	G0105 (HCPCS)	Colorectal cancer screening; colonoscopy on individual at high risk
45383	Lesion removal colonoscopy		

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Supplies Reimbursed Separately When Dispensed from Physician's Office

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A4250	Urine test or reagent strips	Acquisition Cost
A4263	Permanent, long term, non-dissolvable lacrimal duct implant, each. In order to receive payment for this supply, it must be billed with the CPT code 68761, closure of lacrimal punctum; by plug, each.	$5.83
A4300	Implantable vascular access partal/catheter. In order to receive payment for this supply, it must be billed with CPT code 36533, insertion of implantable venous access part, with or without subcutaneous reservoir.	$5.83
Braces, Belts, And Supportive Devices		
A4572	Rib belt	$9.64
4960A	Brace	Acquisition Cost
Miscellaneous Supplies		
A4550	Surgical trays (See list of office procedures that can be billed with this code on pg. N1.)	$5.83
A4561	Pessary rubber, any type	Acquisition Cost
A4562	Pessary, non rubber, any type	Acquisition Cost
A4565	Slings	$6.12
A4570	Splint	$14.30
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code. **(To be used only for cochlear implant replacement parts. Prior authorization is required for the replacement parts and will be manually priced by MAA's authorization department.)**	B.R.
L8600	Breast implants	$650.00
1949M	Tissue expander implant	$950.00
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb extension	Acquisition Cost
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "l" code	Acquisition Cost
Supplies for Radiologic Procedures		
A4641	Supply of radio-pharmaceutical diagnostic imaging agent, not otherwise classified	Acquisition Cost
A4642	Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging, per dose	Acquisition Cost

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A4643	Supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection, (consistent with contrast labeling criteria) Separate payment will be allowed for high dose contrast material when expedited authorized third magnetic resonance imaging (MRI) is performed.	Acquisition Cost
A4644	Supply of Low Osmolar Contrast Material (100-199 mgs of iodine) Brand Name / Generic Name Omnipaque 140 and 180 — Iohexal Optiray 160 — Ioversol	Acquisition Cost
A4645	Supply of Low Osmolar Contrast Material (200-299 mgs of Iodine) Brand Name / Generic Name Omnipaque 210 and 240 — Iohexal Optiray 240 — Ioversol Isovue 200 — Iopamidol	Acquisition Cost
A4646	Supply of Low Osmolar Contrast Material (300-399 mgs of Iodine) Brand Name / Generic Name Omnipaque 300 and 350 — Iohexal Hexabrix — Ioxaglate Optiray 320 — Ioversol Isovue 300 Ultravist	Acquisition Cost
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)	Bundled
A9500	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99M sestamibi, per dose	$80.00
A9502	Supply of radiopharmaceutical diagnostic imaging, technetium tc 99M, tetrofosmin, per unit dose	Acquisition Cost
A9503	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99M, medionate, up to 30 MCI	Acquisition Cost
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m, apcitide	Acquisition Cost
A9505	Supply of radio-pharmaceutical diagnostic imaging agent, thallous chloride TL 201, per MCI	$34.00
A9507	Supply of radiopharmaceutical diagnostic imaging agent, indium in 111 capromab pendetide, per dose	Acquisition Cost
A9508	Supply of radiopharmaceutical diagnostic imaging agent, iobenguane sulfate I-131, per 0.5 mCi	Acquisition Cost
A9510	Supply of radio-pharmaceutical diagnostic imaging agent, technetium TC99M disoferin, per vial	Acquisition Cost
A9600	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per MCI	Acquisition Cost
A9605	Supply of therapeutic radiopharmaceutical samarium sm 153 lexidronamm, 50 mcl	Acquisition Cost

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A9700	Supply of injectable contrast material for use in echocardiography, per study	Acquisition Cost
Q3001	Radioelements for brachytherapy, any type, each	Acquisition Cost
Q3002	Supply of radio-pharmaceutical diagnostic imaging agent, allium GA 67, per mCi	Acquisition Cost
Q3003	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m	Acquisition Cost
Q3004	Supply of radio-pharmaceutical diagnostic imaging agent, xenon XE 133, per 10 mCi	Acquisition Cost
Q3005	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m mertiatide, per mCi	Acquisition Cost
Q3006	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99 glucepatate, per 5 mCi	Acquisition Cost
Q3007	Supply of radio-pharmaceutical diagnostic imaging agent, sodium phosphate P32, per mCi	Acquisition Cost
Q3008	Supply of radio-pharmaceutical diagnostic imaging agent, indium 111 – in pentetreotide, per 3 mCi	Acquisition Cost
Q3009	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m oxidronate per mCi	Acquisition Cost
Q3010	Supply of radio pharmaceutical diagnostic imaging agent, technetium Tc 99m – labeled red blood cells, per mCi	Acquisition Cost
Q3011	Supply of radio-pharmaceutical diagnostic imaging agent, chromic phosphate P32 suspension, per mCi	Acquisition Cost
Q3012	Supply of oral radio-pharmaeutical diagnostic imaging agent, cyanocobalamin cobalt Co57, per 0.5 mCi	Acquisition Cost

Metered Dose Inhalers and Accessories

Effective for claims with dates of service on and after November 1, 2001, state-unique codes 4992A and 4993A are discontinued. ***Please use HCPCS code A4627.***

State-unique code 6645E is discontinued. Please use HCPCS code A4614.

A4614	Peak flow meter	$22.68
A4627	Spacer, bag, or reservoir, with/ without mask (for use with metered dose inhaler	$23.35

Inhalation Solutions

J7610-J7699 (See Section L.)

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting	Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Urinary Tract Implants

Urinary tract implants, listed below, are covered only for treatment of type III stress urinary incontinence resulting from intrinsic sphincter deficiency (ISD) (ICD-9-Dx code 599.82). **The procedure and drug DO NOT require prior authorization, but are limited**. See below and Section I.

Prior to prescribing urinary tract implants, the physician must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

All services provided must be billed on the same claim form:

- CPT code 95028 - skin test for collagen sensitivity; only one is allowed — $5.38
- HCPCS code G0025 - Collagen skin test kit — $33.99
- CPT code 51715 - Implant procedure
  - Non Facility Setting — $172.78
  - Facility Setting — $124.82
- HCPCS code L8603 Collagen implant, urinary tract, per 2.5 ml syringe — $329.80
- HCPCS code L8606 Synthetic implant, urinary tract, per 1 ml syringe — $170.87

NOTE: ***If the implants are done outside the physician's office, then L8603 and L8606 are not allowed.***

MAA will cover the first three (3) implants only, using any combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is 1 implant.

- **All invoices must be retained in the physician's office for supplies that cost less than $50.00**
- **All invoices must be submitted to MAA for supplies that cost $50.00 or more.**

Injection Drug Codes
(HCPCS J- and Q-)

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously.

The injectable drugs can be billed only out of the physician's office supply. Name, strength and dosage of the drug must be documented and retained in the physician's office.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code.
- Claims with HCPCS code J9999 must include drug used, dosage, strength and NDC in the *Comments* field (see page F7.)

All Other Drugs

Provider must attach a copy of the manufacturer's invoices for charges exceeding $1,100.00. For unlisted HCPCS code J3490, an invoice is required for charges exceeding $100.00. Bill number of units used based on the description of the drug code.

HCPCS Code	Description	Maximum Allowable
J0120	Injection, tetracycline, up to 250 mg	Acquisition Cost
J0130	Injection, acbiximab, 10 mg	Acquisition Cost
J0150	Injection, adenosine, 6 mg	Acquisition Cost
J0151	Injection, adenosine, 90 mg	Acquisition Cost
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule	Acquisition Cost
J0190	Injection, biperiden lactate, per 5 mg	Acquisition Cost
J0200	Injection, alatrofloxacin mesylate, 100 mg	Acquistion Cost
J0205	Injection, alglucerase, per 10 units	Acquisition Cost
J0207	Injection, amifostine, 500 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J0210	Injection, methyldopate HCl, up to 250 mg	Acquisition Cost
J0256	Injection, alpha 1 proteinase inhibitor human, 500 mg	Acquisition Cost
J0270	Injection, alprostadil, 1.25 mcg	Acquisition Cost
J0275	Alprostadil urethral suppository (administered under direct physician supervision, excludes self administration)	Acquisition Cost
J0280	Injection, aminophyllin, up to 250 mg	Acquisition Cost
J0282	Injection, amiodarone hydrochloride, 30 mg	Acquisition Cost
J0285	Injection, amphotericin B, 50 mg	Acquisition Cost
J0286	Injection, amphotericin B, any lipid formulation, 50 mg	Acquisition Cost
J0290	Injection, ampicillin, sodium, 500 mg	Acquisition Cost
J0295	Injection, ampicillin sodium/sulbactam sodium, per 1.5 gm	Acquisition Cost
J0300	Injection, amobarbital, up to 125 mg	Acquisition Cost
J0330	Injection, succinylcholine chloride, up to 20 mg	Acquisition Cost
J0340	Injection, nandrolone phenpropionate, up to 50 mg	Acquisition Cost
J0350	Injection, anistreplase, per 30 units	Acquisition Cost
J0360	Injection, hydralazine HCL, up to 20 mg	Acquisition Cost
J0380	Injection, metaraminol, per 10 mg	Acquisition Cost
J0390	Injection, chloroquine HCl, up to 250 mg	Acquisition Cost
J0395	Injection, arbutamine HCL, 1 mg	Acquisition Cost
J0400	Injection, trimethaphan camsylate, up to 500 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J0456	Injection, azithromycin, 500 mg	Acquisition Cost
J0460	Injection, atropine sulfate, up to 0.3 mg	Acquisition Cost
J0470	Injection, dimecaprol, per 100 mg	Acquisition Cost
J0475	Injection, baclofen, 10 mg	Acquisition Cost
J0476	Injection, baclofen, 50 mcg for intrathecal trial	Acquisition Cost
J0500	Injection, dicyclomine HCl, up to 20 mg	Acquisition Cost
J0510	Injection, benzquinamide HCl, up to 50 mg	Acquisition Cost
J0515	Injection, benztropine mesylate, per 1 mg	Acquisition Cost
J0520	Injection, bethanechol chloride, mytonachol or Irecholine, up to 5 mg	Acquisition Cost
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units	Acquisition Cost
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units	Acquisition Cost
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units	Acquisition Cost
J0560	Injection, penicillin G benzathine, up to 600,000 units	Acquisition Cost
J0570	Injection, penicillin G benzathine, up to 1,200,000 units	Acquisition Cost
J0580	Injection, penicillin G benzathine, up to 2,400,000 units	Acquisition Cost
J0585	Botulinum toxin type A, per unit	Acquisition Cost
J0590	Injection, ethylnorepinephrine HCl, 1 ml	Acquisition Cost
J0600	Injection, edetate calcium disodium, up to 1000 mg	Acquisition Cost
J0610	Injection, calcium gluconate, up to 10 ml	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J0620	Injection, calcium glycerophosphate and calcium lactate, up to 10 ml	Acquisition Cost
J0630	Injection, calcitonin-salmon, up to 400 units	Acquisition Cost
J0635	Injection, calcitriol, 1 mcg ampule	Acquisition Cost
J0640	Injection, leucovorin calcium, per 50 mg	Acquisition Cost
J0670	Injection, mepivacaine HCl, per 10 ml	Acquisition Cost
J0690	Injection, cefazolin sodium, 500 mg	Acquisition Cost
J0694	Injection, cefoxitin sodium, 1 g	Acquisition Cost
J0695	Injection, cefonicid sodium, 1 g	Acquisition Cost
J0696	Injection, ceftriaxone sodium, per 250 mg	Acquisition Cost
J0697	Injection, sterile cefuroxime sodium, per 750 mg	Acquisition Cost
J0698	Cefotaxime sodium, per g	Acquisition Cost
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg	Acquisition Cost
J0704	Injection, betamethasone sodium phosphate, per 4 mg	Acquisition Cost
J0710	Injection, cephapirin sodium, up to 1 g	Acquisition Cost
J0713	Injection, deftazidime, per 500 mg	Acquisition Cost
J0715	Injection, ceftizoxime sodium, per 500 mg	Acquisition Cost
J0720	Injection, chloramphenicol sodium succinate, up to 1 g	Acquisition Cost
J0725	Injection, chorionic gonadotropin, per 1000 USP units	Acquisition Cost
J0730	Injection, chlorpheniramine maleate, up to 10 mg	#
J0735	Injection, chloridine hydrochloride, 1 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J0740	Injection, cidofovir, 375 mg	Acquisition Cost
J0743	Injection, cilastatin sodium imipenem, per 250 mg	Acquisition Cost
J0745	Injection, codeine phosphate, per 30 mg	Acquisition Cost
J0760	Injection, colchicine, per 1 mg	Acquisition Cost
J0770	Injection, colistimethate sodium, up to 150 mg	Acquisition Cost
J0780	Injection, prochlorperazine, up to 10 mg	Acquisition Cost
J0800	Injection, corticotropin, up to 40 units	Acquisition Cost
J0810	Injection, cortisone, up to 50 mg	Acquisition Cost
J0835	Injection, cosyntropin, per 0.25 mg	Acquisition Cost
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	Acquisition Cost
J0895	Injection, deferoxamine mesylate, 500 mg per 5 cc	Acquisition Cost
J0900	Injection, testosterone enanthate and estradiol valerate, up to 1 cc	Acquisition Cost
J0945	Injection, brompheniramine maleate, per 10 mg	Acquisition Cost
J0970	Injection, estradiol valerate, up to 40 mg	Acquisition Cost
J1000	Injection, depo-estradiol cypionate, up to 5 mg	Acquisition Cost
J1020	Injection, methylprednisolone acetate, 20 mg	Acquisition Cost
J1030	Injection, methylprednisolone acetate, 40 mg	Acquisition Cost
J1040	Injection, methylprednisolone acetate, 80 mg	Acquisition Cost
J1050	Injection, medroxyprogesterone acetate, 100 mg	Acquisition Cost
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	$47.65

HCPCS Code	Description	Maximum Allowable
J1060	Injection, testosterone cypionate and estradiol cypionate, up to 1 ml	Acquisition Cost
J1070	Injection, testosterone cypionate, up to 100 mg	Acquisition Cost
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	Acquisition Cost
J1090	Injection, testosterone cypionate, 1 cc, 50 mg	Acquisition Cost
J1095	Injection, dexamethasone acetate, per 8 mg	Acquisition Cost
J1100	Injection, dexamethosone sodium phosphate, up to 4 mg/ml	Acquisition Cost
J1110	Injection, dihydroergotamine mesylate, per 1 mg	Acquisition Cost
J1120	Injection, acetazolamide sodium, up to 500 mg	Acquisition Cost
J1160	Injection, digoxin, up to 0.5 mg	Acquisition Cost
J1165	Injection, phenytoin sodium, per 50 mg	Acquisition Cost
J1170	Injection, hydromorphone HCl, up to 4 mg	Acquisition Cost
J1180	Injection, dyphylline, up to 500 mg	Acquisition Cost
J1190	Injection, dexrazoxane hydrochloride, per 250 mg	Acquisition Cost
J1200	Injection, diphenhydramine HCl, up to 50 mg	Acquisition Cost
J1205	Injection, chlorothiazide sodium, per 500 mg	Acquisition Cost
J1212	Injection DMSO, dimethyl sulfoxide, 50%, 50 ml (payable only for installation for the diagnosis of interstitial cystitis [595.1])	Acquisition Cost
J1230	Injection, methadone HCl, up to 10 mg	Acquisition Cost
J1240	Injection, Dimenhydrinate, up to 50 mg	Acquisition Cost
J1245	Injection, dipyridamole, per 10 mg	Acquisition Cost
J1250	Injection, dobutamine HCl, per 250 mg	Acquisition Cost
J1260	Injection, dolasetron mesylate, 10 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J1320	Injection, amitriptyline HCl, up to 20 mg	Acquisition Cost
J1325	Injection, epoprostenol, 0.5 mg	Acquisition Cost
J1327	Injection eptifibatide, 5 mg	Acquisition Cost
J1330	Injection, ergonovine maleate, up to 0.2 mg	Acquisition Cost
J1362	Injection, erythromycin gluceptate, per 250 mg	Acquisition Cost
J1364	Injection, erythromycin lactobionate, per 500 mg	Acquisition Cost
J1380	Injection, estradiol valerate, up to 10 mg	Acquisition Cost
J1390	Injection, estradiol valerate, up to 20 mg	Acquisition Cost
J1410	Injection, estrogen, conjugated, up to 25 mg	Acquisition Cost
J1435	Injection, estrone, per 1 mg	Acquisition Cost
J1436	Injection, etidronate disodium, per 300 mg	Acquisition Cost
J1438	Injection, etanercept, 25 mg (code may be used when drug administered under the direct supervision of a physician, not for use when drug is self-administered).	Acquisition Cost
J1440	Injection, filgrastim, 300 mcg	Acquisition Cost
J1441	Injection, filgrastim (G-CSF), 480 mcg	Acquisition Cost
J1450	Injection, fluconazole, 200 mg	Acquisition Cost
J1452	Injection, intraocular fomivirsen sodium, intraocular, 1.65 mg	Acquisition Cost
J1455	Injection, foscarnet sodium, per 1000 mg	Acquisition Cost
J1460	Injection, gamma globulin, intramuscular, 1 cc	Acquisition Cost
J1470	Injection, gamma globulin, intramuscular, 2 cc	Acquisition Cost
J1480	Injection, gamma globulin, intramuscular, 3 cc	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J1490	Injection, gamma globulin, intramuscular, 4 cc	Acquisition Cost
J1500	Injection, gamma globulin, intramuscular, 5 cc	Acquisition Cost
J1510	Injection, gamma globulin, intramuscular, 6 cc	Acquisition Cost
J1520	Injection, gamma globulin, intramuscular, 7 cc	Acquisition Cost
J1530	Injection, gamma globulin, intramuscular, 8 cc	Acquisition Cost
J1540	Injection, gamma globulin, intramuscular, 9 cc	Acquisition Cost
J1550	Injection, gamma globulin, intramuscular, 10 cc	Acquisition Cost
J1560	Injection, gamma globulin, intramuscular, over 10 cc	Acquisition Cost
J1561	Injection, immune globulin, intravenous, per 500 mg	Acquisition Cost
J1563	Injection, immune globulin, intravenous, 1 gm	Acquisition Cost
J1565	Injection, respiratory syncytial virus immune globulin, Intravenous, 50 mg **(Respigam only)**	Acquisition Cost
J1570	Injection, ganciclovir sodium, 500 mg	Acquisition Cost
J1580	Injection, garamycin, gentamicin, up to 80 mg	Acquisition Cost
J1600	Injection, gold sodium thiomaleate, up to 50 mg	Acquisition Cost
J1610	Injection, glucagon hydrochloride, per 1 mg	Acquisition Cost
J1620	Injection, gonadorelin hydrochloride, per 1000 mcg	Acquisition Cost
J1626	Injection, granisetron hydrochloride, 100 mcg	Acquisition Cost
J1630	Injection, haloperidol, up to 5 mg	Acquisition Cost
J1631	Injection, haloperidol decanoate, per 50 mg	Acquisition Cost
J1642	Injection, heparin sodium, (Heparin Lock Flush), per 10 units	Acquisition Cost
J1644	Injection, heparin sodium, per 1000 units	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J1645	Injection, dalteparin sodium, per 2500 1 unit	Acquisition Cost
J1650	Injection, enoxaparin sodium, 30 mg	Acquisition Cost
J1670	Injection, tetanus immune globulin, human, up to 250 units	Acquisition Cost
J1690	Injection, prednisolone tebutate, up to 20 mg	Acquisition Cost
J1700	Injection, hydrocortisone acetate, up to 25 mg	Acquisition Cost
J1710	Injection, hydrocortisone sodium phosphate, up to 50 mg	Acquisition Cost
J1720	Injection, hydrocortisone sodium succinate, up to 100 mg	Acquisition Cost
J1730	Injection, diazoxide, up to 300 mg	Acquisition Cost
J1739	Injection, hydroxyprogesterone caprocate, 125 mg/ml	Acquisition Cost
J1741	Injection, hydroxyprogesterone caproate, 250 mg/ml	Acquisition Cost
J1742	Injectioin, ibutrilide fumarate, 1 mg	Acquisition Cost
J1745	Injection, infliximab, 10 mg	Acquisition Cost
J1750	Injection, iron dextran, 50 mg	Acquisition Cost
J1785	Injection, imiglucerase, per unit	Acquisition Cost
J1790	Injection, droperidol, up to 5 mg	Acquisition Cost
J1800	Injection, propranolol HCl, up to 1 mg	Acquisition Cost
J1810	Injection, droperidol and fentanyl citrate, up to 2 ml ampule	Acquisition Cost
J1820	Injection, insulin, up to 100 units	Acquisition Cost
J1825	Injection, interferon beta-1A, 33 mcg	Acquisition Cost
J1830	Injection interferon beta-1, per .25 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J1840	Injection, kanamycin sulfate, up to 500 mg	Acquisition Cost
J1850	Injection, kanamycin sulfate, up to 75 mg	Acquisition Cost
J1885	Injection, ketoralac tromethamine, per 15 mg	Acquisition Cost
J1890	Injection, cephalothin sodium, up to 1 g	Acquisition Cost
J1910	Injection, kutapressin, up to 2 ml	Acquisition Cost
J1930	Injection, propiomazine HCl, up to 20 mg	Acquisition Cost
J1940	Injection, furosemide, up to 20 mg	Acquisition Cost
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Acquisition Cost
J1955	Injection, levocarnitine, per 1 gm	Acquisition Cost
J1956	Injection, levofloxacin, 250 mg	Acquisition Cost
J1960	Injection, levorphanol tartrate, up to 2 mg	Acquisition Cost
J1970	Injection, methotrimeprazine, up to 20 mg	Acquisition Cost
J1980	Injection, hyoscyamine sulfate, up to 0.25 mg	Acquisition Cost
J1990	Injection, chlordiazepoxide HCl, up to 100 mg	Acquisition Cost
J2000	Injection, lidocaine HCl, 50 cc	Acquisition Cost
J2010	Injection, lincomycin HCl, up to 300 mg	Acquisition Cost
J2060	Injection, lorazepam, 2 mg	Acquisition Cost
J2150	Injection, mannitol, 25% in 50 ml	Acquisition Cost
J2175	Injection, meperidine HCl, per 100 mg	Acquisition Cost
J2180	Injection, meperidine and promethazine HCl, up to 50 mg	Acquisition Cost
J2210	Injection, methylergonovine maleate, up to 0.2 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J2240	Injection, metocurine iodide, up to 2 mg	Acquisition Cost
J2250	Injection, midazolam HCl, per 1 mg	Acquisition Cost
J2260	Injection, milrinon lactate, per 5 ml	Acquisition Cost
J2270	Injection, morphine sulfate, up to 10 mg	Acquisition Cost
J2271	Injection, morphine sulfate, 100 mg	Acquisition Cost
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	Acquisition Cost
J2300	Injection, nalbuphine HCl, per 10 mg	Acquisition Cost
J2310	Injection, naloxone HCl, up to 1 mg	Acquisition Cost
J2320	Injection, nandrolone decanoate, up to 50 mg	Acquisition Cost
J2321	Injection, nandrolone decanoate, up to 100 mg	Acquisition Cost
J2322	Injection, nandrolone decanoate, up to 200 mg	Acquisition Cost
J2330	Injection, thiothixene, up to 4 mg	Acquisition Cost
J2350	Injection, niacinamide, niacin, up to 100 mg	Acquisition Cost
J2352	Injection, octreotide acetate, 1 mg	Acquisition Cost
J2355	Injection, oprelvekin, 5 mg	Acquisition Cost
J2360	Injection, orphenadrine citrate, up to 60 mg	Acquisition Cost
J2370	Injection, phenylephrine HCl, up to 1 ml	Acquisition Cost
J2400	Injection, chloroprocaine HCl, per 30 ml	Acquisition Cost
J2405	Injection odansetron HCl, per 1 mg	Acquisition Cost
J2410	Injection, oxymorphone HCl, up to 1 mg	Acquisition Cost
J2430	Injection, pamidronate disodium, per 30 mg	Acquisition Cost
J2440	Injection, papaverine HCl, up to 60 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J2460	Injection, oxytetracycline HCl, up to 50 mg	Acquisition Cost
J2480	Injection, hydrochlorides of opium alkaloids, up to 20 mg	Acquisition Cost
J2500	Injection, paricalcitol, 5 mcg	Acquisition Cost
J2510	Injection, penicillin G procaine, aqueous, up to 600,000 units	Acquisition Cost
J2512	Injection, pentagastrin, per 2 ml	Acquisition Cost
J2515	Injection, pentobarbital sodium, per 50 mg	Acquisition Cost
J2540	Injection, penicillin G potassium, up to 600,000 units	Acquisition Cost
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 gram 0.125 grams (1.125 grams)	Acquisition Cost
J2545	Pentamidine isethionate, inhalation solution, per 300 mg. Carinii pneumonia treatment for prophylaxis	Acquisition Cost
J2550	Injection, promethazine HCl, up to 50 mg	Acquisition Cost
J2560	Injection, phenobarbital sodium, up to 120 mg	Acquisition Cost
J2590	Injection, oxytocin, up to 10 units (Pitocin, Syntocinon)	Acquisition Cost
J2597	Injection, desmopressin acetate, per 1 mcg	Acquisition Cost
J2640	Injection, prednisolone sodium phosphate, to 20 mg	Acquisition Cost
J2650	Injection, prednisolone acetate, up to 1 ml	Acquisition Cost
J2670	Injection, tolazoline HCl, up to 25 mg	Acquisition Cost
J2675	Injection, progesterone (Gesterol 50, Progestaject), per 50 mg	Acquisition Cost
J2680	Injection, fluphenazine decanoate, up to 25 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J2690	Injection, procainamide HCl, up to 1 g	Acquisition Cost
J2700	Injection, oxacillin sodium, up to 250 mg	Acquisition Cost
J2710	Injection, neostigmine methylsulfate, up to 0.5 mg	Acquisition Cost
J2720	Injection, protamine sulfate, up to 10 mg	Acquisition Cost
J2725	Injection, protirelin, per 250 mcg	Acquisition Cost
J2730	Injection, pralidoxime chloride, up to 1 g	Acquisition Cost
J2760	Injection, phentolamine mesylate, up to 5 mg	Acquisition Cost
J2765	Injection, metoclopramide HCl, up to 10 mg	Acquisition Cost
J2770	Injection, quinupristin/dalforpristin, 500 mg (150/350)	Acquisition Cost
J2780	Injection, ranitidine hydrochloride, 25 mg	Acquisition Cost
J2790	Injection, Rho (D) immune globulin, human, one dose package	Acquisition Cost
J2792	Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU	Acquisition Cost
J2795	Injection, ropivacaine HCL, 1 mg	Acquisition Cost
J2800	Injection, methocarbamol, up to 10 ml	Acquisition Cost
J2810	Injection, theophylline, per 40 mg	Acquisition Cost
J2820	Injection, sargramostim (GM-CSF), 50 mg	Acquisition Cost
J2860	Injection, secobarbital sodium, up to 250 mg	Acquisition Cost
J2910	Injection, aurothioglucose, up to 50 mg	Acquisition Cost
J2912	Injection, sodium chloride, 0.9%, per 2 ml	Acquisition Cost
J2915	Injection, sodium ferric gluconate complex in sucrose injection, 62.5 mg	Acquisition Cost
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	Acquisition Cost
J2950	Injection, promaxine HCl, up to 25 mg	Acquisition Cost
J2970	Injection, methicillin sodium, up to 1 g	Acquisition Cost
J2993	Injection, reteplase, 18.8 mg	Acquisition Cost
J2995	Injection, streptokinase, per 250,000 IU	Acquisition Cost
J2997	Injection, alteplase recombinant, 1 mg	Acquisition Cost
J3000	Injection, streptomycin, up to 1 g	Acquisition Cost
J3010	Injection, fentanyl citrate, up to 2 ml	Acquisition Cost
J3030	Injection, sumatriptan succinate, 6 mg	Acquisition Cost
J3070	Injection, pentazocine HCl, up to 30 mg	Acquisition Cost
J3080	Injection, chlorprothixene, up to 50 mg	Acquisition Cost
J3105	Injection, terbutaline sulfate, up to 1 mg	Acquisition Cost
J3120	Injection, testosterone enanthate, up to 100 mg	Acquisition Cost
J3130	Injection, testosterone enanthate, up to 200 mg	Acquisition Cost
J3140	Injection, testosterone suspension, up to 50 mg	Acquisition Cost
J3150	Injection, testosterone propionate, up to 100 mg	Acquisition Cost
J3230	Injection, chlorpromazine HCl, up to 50 mg	Acquisition Cost
J3240	Injection, thyrotropin, alpha 0.9 mg	Acquisition Cost
J3245	Injection, tirofiban hydrochloride, 12.5 mg	Acquisition Cost
J3250	Injection, trimethobenzamide HCl, up to 200 mg	Acquisition Cost
J3260	Injection, tobramycin sulfate, up to 80 mg	Acquisition Cost
J3265	Injection, torsemide, 10 mg/ml	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J3270	Injection, imipramine HCl, up to 25 mg	Acquisition Cost
J3280	Injection, thiethylperazine maleate, up to 10 mg	Acquisition Cost
J3301	Injection, triamcinolone acetonide, per 10 mg	Acquisition Cost
J3302	Injection, triamcinolone diacetate, per 5 mg	Acquisition Cost
J3303	Injection, triamcinolone hexacetonide, per 5 mg	Acquisition Cost
J3305	Injection, trimethrexate glucaronate, per 25 mg	Acquisition Cost
J3310	Injection, perphenazine, up to 5 mg	Acquisition Cost
J3320	Injection, spectinomycin dihydrochloride, up to 2 g	Acquisition Cost
J3350	Injection, urea, up to 40 g	Acquisition Cost
J3360	Injection, diazepam, up to 5 mg	Acquisition Cost
J3364	Injection, urokinase, 5000 IU vial	Acquisition Cost
J3365	Injection, IV, urokinase, 250,000 IU vial	Acquisition Cost
J3370	Injection, vancomycin, HCl, up to 500 mg	Acquisition Cost
J3390	Injection, methoxamine HCl, up to 20 mg	Acquisition Cost
J3400	Injection, trifluprom azine HCl, up to 20 mg	Acquisition Cost
J3410	Injection, hydroxyzine HCl, up to 25 mg	Acquisition Cost
J3420	Injection, vitamin B-12 cyanocobalamin, up to 1000 mcg (Vitamin B-12 is allowed for diseases or conditions that cause anemia and malabsorption, such as Crohn's Disease, ilectomy, pernicious anemia or fish tapeworm infestation.	Acquisition Cost
J3430	Injection, phytonadione (vitamin K), per 1 mg	Acquisition Cost
J3450	Injection, mephentermine sulfate, up to 30 mg	Acquisition Cost
J3470	Injection, hyaluronidase, up to 150 units	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J3475	Injection, magnesium sulphate, per 500 mg	Acquisition Cost
J3480	Injection, potassium chloride, per 2 mEq	Acquisition Cost
J3485	Injection, zidovudine, 10 mg	Acquisition Cost
J3490	Unclassified drugs	Invoice must be submitted for drugs costing $100.00 or more (indicating drug strength and dosage (quantity used)
J3520	Eretate disodium	#
J3530	Nasal vaccine inhalation	Acquisition Cost
J3535	Drug administered through a metered dose inhaler	Acquisition Cost
J3570	Laetrile, amygdalin, vitamin B-17	#
Miscellaneous Drugs And Solutions		
J7030	Infusion, normal saline solution, 1000 cc	Acquisition Cost
J7040	Infusion, normal saline solution, sterile (500 ml = 1 unit)	Acquisition Cost
J7042	5% dextrose/normal saline (500 ml = 1 unit)	Acquisition Cost
J7050	Infusion, normal saline solution, 250 cc	Acquisition Cost
J7051	Sterile saline or water, up to 5 cc	Acquisition Cost
J7060	5% dextrose/water (500 ml = 1 unit)	Acquisition Cost
J7070	Infusion, D-5-W, 1000 cc	Acquisition Cost
J7100	Infusion, dextran 40, 500 ml	Acquisition Cost
J7110	Infusion, dextran 75, 500 ml	Acquisition Cost
J7120	Ringers lactate infusion, up to 1000 cc	Acquisition Cost
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J7190	Factor VIII, (anti-hemophilic factor (human)), per IU	#
J7191	Factor VIII, (anti-hemophilic factor (porcine)), per IT	#
J7192	Factor VIII (antihemophilic factor (Recombinant), per IU	#
J7194	Factor IX, complex, per unit	#
J7197	Antithrombin III (human), per IU	#
J7198	Anti-inhibitor, per I.U.	Acquisition Cost
J7199	Hemophilia clotting factor, not otherwise classified	Acquisition Cost
J7300	Intrauterine copper contraceptive	$299.00
J7310	Ganciclovir, 4.5 mg, long acting implant	Acquisition Cost
J7315	Sodium hyaluronate, 20 mg for intra articular injection	$132.20
J7320	Hylan G-F 20, 16 mg, for intra-articular injection	$215.65
Immunosuppressive Drugs		
J7500	Azathioprine - oral, 50 mg	#
J7501	Azathioprine - parenteral, 100 mg	#
J7503	Cyclosporine - parenteral, per 50 mg	#
J7504	Lymphocyte immune globulin, antythymocyte globulin parenteral, 250 mg	#
J7505	Monoclonal antibodies - parenteral, 5 mg/5 ml, 5 ml ea	#
J7506	Prednisone, oral, per 500 mg	#
J7507	Tacrolimus, oral, per 1 mg	Acquisition Cost
J7508	Tacrolimus, oral, per 5 mg	Acquisition Cost
J7509	Methylprednisolone, oral, per 4 mg (Medrol)	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J7510	Prednisolone, oral, per 5 mg (Delta-Cortef)	Acquisition Cost
J7513	Daclizumab, parenteral, 25 mg	Acquisition Cost
J7515	Cyclosporine, oral, 25 mg	Acquisition Cost
J7516	Cyclosporine, parenteral, 250 mg	Acquisition Cost
J7517	Mycophenolate mofetil, oral, 250 mg	Acquisition Cost
J7520	Sirolimus, oral, 1 mg	Acquisition Cost
J7525	Tacrolimus, parenteral, 5 mg	Acquisition Cost
J7599	Immunosuppressive drug, not otherwise classified	Acquisition Cost
Inhalation Solutions		
J7608	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram	Acquisition Cost
J7618	Albuterol, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7619	Albuterol, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7628	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7629	Bitolterol mesylate, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7631	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams	Acquisition Cost
J7635	Atropine, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7636	Atropine, inhalation solution administered through DME, unit dose form, per miligram	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J7637	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7638	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7639	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7642	Glycopyrrolate, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7643	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7644	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7648	Isoetharine HCl, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7649	Isoetharine HCl, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7658	Isoproterenol HCl, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7659	Isoproterenol HCl, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7668	Metaproterenol sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams	Acquisition Cost
J7669	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams	Acquisition Cost
J7680	Terbutaline sulfate, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7681	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution, administered through DME	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
J7683	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram	Acquisition Cost
J7684	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram	Acquisition Cost
J7699	NOC drugs, inhalation solution administered through DME	Acquisition Cost
J7799	NOC drugs, other than nhalation drugs, administered through DME	Acquisition Cost
J8499	Prescription drug, oral, non chemotherapeutic (Not otherwise specified)	Acquisition Cost
J8510	Busulfan; oral, 2 mg	Acquisition Cost
J8520	Capecitabine, oral, 150 mg	Acquisition Cost
J8530	Cyclophosphamide; oral 25 mg	Acquisition Cost
J8560	Etoposide; oral, 50 mg	Acquisition Cost
J8600	Melphalan; oral, 2 mg	Acquisition Cost
J8610	Methotrexate; oral, 2.5 mg	Acquisition Cost
J8700	Temozolmide, oral, 5 mg	Acquisition Cost
J8999	Prescription drug, oral, chemotherapeutic, not otherwise specified	Acquisition Cost
Chemotherapy Drugs		
J9000	Doxorubicin HCl, 10 mg	$42.82
J9001	Doxorubicin hydrochloride, all lipid formulations, 10 mg	$358.96
J9015	Aldesleukin, per single use vial	$641.25
J9020	Asparaginase, 10,000 units	$59.70
J9031	BCG live (intravesical), per installation	$166.49

HCPCS Code	Description	Maximum Allowable
J9040	Bleomycin sulfate, 15 units	$289.37
J9045	Carboplatin, 50 mg	$111.11
J9050	Carmustine, 100 mg	$114.41
J9060	Cisplatin, powder or solution, per 10 mg	$43.08
J9062	Cisplatin, 50 mg	$215.44
J9065	Injection, cladribine, per 1 mg	$56.09
J9070	Cyclophosphamide, 100 mg	$5.98
J9080	Cyclophosphamide, 200 mg	$11.34
J9090	Cyclophosphamide, 500 mg	$23.81
J9091	Cyclophosphamide, 1 g	$47.64
J9092	Cyclophosphamide, 2 g	$95.27
J9093	Cyclophosphamide, lyophilized, 100 mg	$6.13
J9094	Cyclophosphamide, lyophilized, 200 mg	$11.64
J9095	Cyclophosphamide, lyophilized, 500 mg	$24.42
J9096	Cyclophosphamide, lyophilized, 1 g	$48.86
J9097	Cyclophosphamide, lyophilized, 2 g	$97.75
J9100	Cytarabine, 100 mg	$5.94
J9110	Cytarabine, 500 mg	$23.75
J9120	Dactinomycin, 0.5 mg	$12.73
J9130	Dacarbazine, 100 mg	$12.68
J9140	Dacarbazine, 200 mg	$23.94
J9150	Daunorubicin HCl, 10 mg	$80.04

HCPCS Code	Description	Maximum Allowable
J9151	Daunorubicin citrate, liposomal formulation, 10 mg	$64.60
J9160	Denileukin diftitox, 300 mcg	$999.88
J9165	Diethylstilbestrol diphosphate, 250 mg	$14.41
J9170	Docetaxel, 20 mg	$297.83
J9180	Epirubicin hydrochloride, 50 mg	$623.44
J9181	Etoposide, 10 mg	$10.45
J9182	Etoposide, 100 mg	$104.50
J9185	Fludarabine phosphate, 50 mg	$258.58
J9190	Fluorouracil, 500 mg	$2.47
J9200	Floxuridine, 500 mg	$129.56
J9201	Gemcitabine HCI, 200 mg	$102.13
J9202	Goserelin acetate implant, per 3.6 mg	$446.49
J9206	Irinotecan, 20 mg	$134.25
J9208	Ifosfamide, 1 gm	$156.65
J9209	Mesna, 200 mg	$40.45
J9211	Idarubicin HCl, 5 mg	$412.21
J9212	Injection, interferon alfacon-1, recombinant, 1 mcg	$4.09
J9213	Interferon alfa-2a, recombinant, 3 million units (Roferon-A)	$34.88
J9214	Interferon alfa-2b, recombinant, 1 million units (Intron A)	$11.29
J9215	Interferon alfa-N3 (human leukocyte derived), 250,000 IU (Alferon N)	$7.86
J9216	Interferon gamma-1B, 3 million units (Actimmune)	$285.65

HCPCS Code	Description	Maximum Allowable
J9217	Leuprolide acetate (for depot suspension), 7.5 mg (Lupron)	$446.69
J9218	Leuprolide acetate, per 1 mg (Lupron)	$75.31
J9219	Leuprolide acetate implant, 65 mg	$5,399.80
J9230	Mechlorethamine HCl (nitrogen mustard), 10 mg	$11.45
J9245	Injection, melphalan HCl, 50 mg	$381.65
J9250	Methotrexate sodium, 5 mg	$.46
J9260	Methotrexate sodium, 50 mg	$4.51
J9265	Paclitaxel, 30 mg (Taxol)	$164.07
J9266	Pegaspargase, per single dose vial	$1,321.65
J9268	Pentostatin, per 10 mg	$1,723.06
J9270	Plicamycin, 2.5 mg	$93.80
J9280	Mitomycin, 5 mg	$124.53
J9290	Mitomycin, 20 mg	$413.72
J9291	Mitomycin, 40 mg	$869.25
J9293	Mitoxantrone HCl, per 5 mg	$244.21
J9310	Rituximab, 100 mg	$454.55
J9320	Streptozocin, 1 gm	$117.64
J9340	Thiotepa, 15 mg	$116.97
J9350	Topotecan, 4 mg	$632.56
J9355	Trastuzuma B	$52.83
J9357	Valrubicin, intravesical, 200 mg.	$423.23

HCPCS Code	Description	Maximum Allowable
J9360	Vinblastine sulfate, 1 mg	$4.10
J9370	Vincristine sulfate, 1 mg	$32.07
J9375	Vincristine sulfate, 2 mg	$52.16
J9380	Vincristine sulfate, 5 mg	$154.57
J9390	Vinorelbine tartrate, per 10 mg	$90.73
J9600	Porfimer sodium, 75 mg	$2,603.67
J9999	Not otherwise classified, antineoplastic drugs	By Report (See Section F for policy)

Injection Codes For Epoetin Alfa (EPO)

Q0136	Injection, Epoetin Alpha, (for non ESRD use), per 1000 units	$11.00
Q9920	Injection of EPO, per 1000 units, at patient HCT of 20 or less	$11.00
Q9921	Injection of EPO, per 1000 units, at patient HCT of 21	$11.00
Q9922	Injection of EPO, per 1000 units, at patient HCT of 22	$11.00
Q9923	Injection of EPO, per 1000 units, at patient HCT of 23	$11.00
Q9924	Injection of EPO, per 1000 units, at patient HCT of 24	$11.00
Q9925	Injection of EPO, per 1000 units, at patient HCT of 25	$11.00
Q9926	Injection of EPO, per 1000 units, at patient HCT of 26	$11.00

HCPCS Code	Description	Maximum Allowable
Q9927	Injection of EPO, per 1000 units, at patient HCT of 27	$11.00
Q9928	Injection of EPO, per 1000 units, at patient HCT of 28	$11.00
Q9929	Injection of EPO, per 1000 units, at patient HCT of 29	$11.00
Q9930	Injection of EPO, per 1000 units, at patient HCT of 30	$11.00
Q9931	Injection of EPO, per 1000 units, at patient HCT of 31	$11.00
Q9932	Injection of EPO, per 1000 units, at patient HCT of 32	$11.00
Q9933	Injection of EPO, per 1000 units, at patient HCT of 33	$11.00
Q9934	Injection of EPO, per 1000 units, at patient HCT of 34	$11.00
Q9935	Injection of EPO, per 1000 units, at patient HCT of 35	$11.00
Q9936	Injection of EPO, per 1000 units, at patient HCT of 36	$11.00
Q9937	Injection of EPO, per 1000 units, at patient HCT of 37	$11.00
Q9938	Injection of EPO, per 1000 units, at patient HCT of 38	$11.00
Q9939	Injection of EPO, per 1000 units, at patient HCT of 39	$11.00
Q9940	Injection of EPO, per 1000 units, at patient HCT of 40	$11.00

HCPCS Code	Description	Maximum Allowable
Antihemophilic		
Q0160	Factor IX (antihemophilic factor, purified, non-recombinant) per I.U.	Acquisition Cost
Q0161	Factor IX (antihemophilic factor, recombinant) per I.U.	Acquisition Cost
Q0187	Factor VIAA (coagulation factor, recombinant) per 1.2 mg	Acquisition Cost
Oral Anti-emetic (Nausea) Drugs		
Q0163	Diphenhydramine hydrochloride, 50 mg	Acquisition Cost
Q0164	Prochlorperazine maleate, 5 mg	Acquisition Cost
Q0165	Prochlorperazine maleate, 10 mg	Acquisition Cost
Q0166	Granisetron hydrochloride, 1 mg	Acquisition Cost
Q0167	Dronabinol, 2.5 ml	Acquisition Cost
Q0168	Dronabinol 5 mg	Acquisition Cost
Q0169	Promethazine hydrochloride, 12.5 mg	Acquisition Cost
Q0170	Promethazine hydrochloride, 25 mg	Acquisition Cost
Q0171	Chlorpromazine hydrochloride, 10 mg	Acquisition Cost
Q0172	Chlorpromazine hydrochloride, 25 mg	Acquisition Cost
Q0173	Trimehobenzamide hydrochloride, 250 mg	Acquisition Cost
Q0174	Thiethylperazine maleate, 10 mg	Acquisition Cost
Q0175	Perphenazine, 4 mg	Acquisition Cost
Q0176	Perphenazine, 8 mg	Acquisition Cost
Q0177	Hydroxyzine pamoate, 25 mg	Acquisition Cost
Q0178	Hydroxyzine pamoate, 50 mg	Acquisition Cost
Q0179	Ondansetron hydrochloride, 8 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
Q0180	Dolasetron hydrochloride, 8 mg	Acquisition Cost
Q0181	Unspecified oral dosage form FDA approved, prescription anti-emetic for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regime.	Acquisition Cost
Miscellaneous		
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	Acquisition Cost
Q2001	Oral, cabergoline 0.5 mg	Acquisition Cost
Q2002	Injection, Elliott's B solution, per ml	Acquisition Cost
Q2003	Injection, aprotinin, 10,000 ki	Acquisition Cost
Q2004	Irrigation solution for treatment of bladder calculi, for example renacidin, per 500 ml	Acquisition Cost
Q2005	Injection, corticorelin ovine triflutate, per dose	Acquisition Cost
Q2006	Injection, digoxin immune fab (ovine), per vial	Acquisition Cost
Q2007	Injection, ethanolamine oleate, 100 mg	Acquisition Cost
Q2008	Injection, fomepizole, 1.5 mg	Acquisition Cost
Q2009	Injection, fosphenytoin, 50 mg	Acquisition Cost
Q2010	Injection, glatiramer acetate, per dose	Acquisition Cost
Q2011	Injection, hemin, per 1 mg	Acquisition Cost
Q2012	Injection, pegademase bovine, 25 iu	Acquisition Cost
Q2013	Injection, pentastarch, 10% solution, per 100 ml	Acquisition Cost
Q2014	Injection, sermorelin acetate, 0.5 mg	Acquisition Cost
Q2015	Injection, somatrem, 5 mg	Acquisition Cost
Q2016	Injection, somatropin, 1 mg	Acquisition Cost

HCPCS Code	Description	Maximum Allowable
Q2017	Injection, teniposide, 50 mg	Acquisition Cost
Q2019	Injection, basiliximab, 20 mg	Acquisition Cost
Q2020	Injection, histrelin acetate, 10 mg	Acquisition Cost
Q2021	Injection, lepirudin, 50 mg	Acquisition Cost
Q2022	von Willebrand factor complex, per iu	Acquisition Cost

CPT/HCPCS Modifiers

[Refer to WAC 388-531-18050(10)(11)]

Italics are used to set off "additional" MAA language not found in CPT.

21: **Prolonged Evaluation and Management Services**: *For informational purposes only*; *no extra allowance will be allowed.*

22: **Unusual Procedural Services**: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior sugery, irradiation, infection, very low weight or trauma. *For informational purposes only; no extra allowance will be allowed.*

23: **Unusual Anesthesia**: *For informational purposes only*; *no extra allowance will be allowed.*

24: **Unrelated Evaluation and Management (E&M) by the Same Physician During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) ***unrelated*** to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E&M service. *Payment for the E&M service during postoperative period is made when the reason for the E&M service is unrelated to original procedure.*

25: **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure:** The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the client's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of E&M service. *Payment for the E&M service is the billed charge or MAA's maximum allowable, whichever is less; supporting documentation may be submitted with the claim.*

26: **Professional Component:** Certain procedures are a combination of professional and technical components. When only the professional component is reported, the service is identified by adding modifier 26 to the procedure code.

TC: **Technical Component:** Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. *A "special agreement" with MAA is required if services are performed in a hospital setting. (Refer to the Level III, state-unique modifiers section for the address used to request special agreements.)*

32: **Mandated Services**: *For informational purposes only*; *no extra allowance will be allowed.*

47: **Anesthesia By Surgeon:** *Not covered by MAA.*

50: **Bilateral Procedure:** Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding this modifier to the appropriate five-digit code describing the first procedure.

For surgical procedures typically performed on both sides of the body, payment for the E&M service is the billed charge or MAA' maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

51: **Multiple Procedures**: *When multiple surgeries are performed on the same client at the same operative session total payment is equal to the sum of the 100% of the global fee for the highest value procedure; 50% of the global fee for the second through fifth procedures. Procedures in excess of five require submission of documentation and individual review to determine the payment amount.*

52: **Reduced Services**: Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. *Using this modifier will not reduce the allowance to the provider. Note: Modifier 52 may be used with computerized tomography numbers for a limited study or a follow-up study.*

53: **Discontinued Procedure**: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 only. It is "information only" for all other surgical procedures.

54, 55, 56 - Providers providing less than the global surgical package should use modifiers 54, 55, & 56. *These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the claimant. The breakdown is as follows:*

54: **Surgical Care Only**: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. *A specific percentage of the global surgical payment in the Physician Related Services Fee Schedule is made for the surgical procedure only*.

55: **Postoperative Management Only**: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. *A specific percentage of the global surgical payment in the Physician Related Services Fee Schedule is made for the surgical procedure only*.

56: **Preoperative Management Only**: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. *A specific percentage of the global surgical payment in the Physician Related Services Fee Schedule is made for the surgical procedure only*.

57: **Decision for Surgery**: An evaluation and management (E&M) service provided the day before or day of surgery that resulted in the initial decision to perform the surgery, may be identified by adding the modifier 57 to the appropriate level of E&M service. *This does not apply to minor surgeries (those with a follow-up period of less than 90 days).*

58: **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive that the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. *NOTE: This modifier is not used to report the treatment of a problem that requires a return to the original room. See modifier 78.*

59: **Distinct Procedural Service**: The physician must indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of surgery in extensive injuries). *This modifier is information only.*

60: **Altered Surgical Field**: *For informational purposes only*; *no extra allowance will be allowed.*

62: **Two Surgeons**: Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting his/her services.
Payment for this modifier is 125% of the global surgical fee in the RBRVS Fee Schedule. The payment is divided equally between the two surgeons. No payment is made for an assistant-at-surgery in this case.

66: **Team Surgery:** *For informational purposes only*; *no extra allowance will be allowed.*

76: **Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated. This may be reported by adding the modifier 76 to the repeated service.

77: **Repeat Procedure by Another Physician:** *For informational purposes only*; *no extra allowance will be allowed.*

78: **Return to the Operating Room for a Related Procedure During the Postoperative Period:** The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. ***When multiple procedures are performed, use modifier 78 on EACH detail line.*** *Payment for these procedures is the percentage of the global package for the intra-operative services. Assistant surgeons and anesthesiologists must use modifier 99 to indicate an additional operating room procedure. They must indicate modifier 78 and 80 or 78 and the appropriate anesthesia modifier on the claim in the remarks column.*

79: **Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

80: **Assistant Surgeon**: Surgical assistant and/or physician assistant services must be identified by adding modifier 80 to the usual procedure code(s). *A physician assistant employed by a physician, must use the physician's provider number and must bill on the same claim form as the physician/surgeon. Payment is 20% of the maximum allowance*.

81: **Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. *Payment is 20% of the maximum allowance.*

82: **Assistant Surgeon (When Qualified Resident Surgeon Not Available)**: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). *Payment is 20% of the maximum global allowance.*

90: **Reference (Outside) Laboratory:** When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. *The referenced lab provider number must be entered in the performing number field on the HCFA-1500 claim form or electronic claim record. The referral lab must be CLIA certified.*

91: Repeat Clinical Diagnostic Laboratory Test Performed on the same day to obtain subsequent report test value(s) (Separate Specimens Taken in Separate Encounter(s)) has been added. ***This modifier does affect payment***. *Modifier 91 should be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use 91 modifier with the appropriate procedure code.*

99: **Multiple Modifiers**: Under certain circumstances two or more modifiers may be necessary to completely describe a service. *Modifier 99 must be used **only when two or more modifiers affect pricing** (applicable modifiers in list below). Modifier 99 must be added to the basic procedure, and two or more of the applicable modifiers from the list below must be listed in field 24D.*

26	Professional component
50	Bilateral surgery
53	Discontinued procedure
54	Surgical care only
55	Post-operative management only
56	Pre-operative management only
62	Two surgeons
66	surgical team
78	Return to operating room for related procedure during post-op period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
TC	Technical component
1M	Special agreement
1C	Children's services
1H	Health department
LT	Left
RT	Right
1R	Radiological consultation
91	Repeat clinical diagnostic lab, same day
9T	Major trauma

QP Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes. *This modifier is now used FOR INFORMATION ONLY. Internal control reimbursement methodology for automated multi-channel tests will be applied. This modifier is not appropriate to use when billing for repeat tests or to indicate not as a panel.*

Q6 **Physician Services**: Services furnished by a locum tenens physician. *For informational purposes only; no extra allowance will be allowed.*

Level III
State-Unique Modifiers

1C **Children's Primary Health Care**: Use to receive a pediatric reimbursement rate for children's primary health care and office/outpatient procedure codes (CPT codes 99201-99215) when services are provided for a baby, and are billed using the parent's PIC. **Do not use this modifier when billing under baby's PIC.**

1H **Immunization Material Obtained from a Health Department** (clients 18 years of age and younger): Use with the appropriate immunization procedure code to identify that the immunization material was obtained from a health department. **Do not bill this modifier in combination with 90471 or 90472.**

1M **Use of Facility or Equipment Owned by the Physician Used in Outpatient Hospital or Emergency Room**: This modifier is to be used by providers who have an existing "special agreement with MAA."

1R **Consultation on X-ray Examination**: When billing a consultation, the consulting physician should bill the specific radiological x-ray code with modifier 1R (Professional Component). For example, the initial physician would bill with the global chest x-ray (CPT code 71020) or the professional component (71020-26), but the second consulting physician would bill only for the chest x-ray consultations (e.g., 71020-1R).

9T **Major Trauma**: Use to enhance payment for direct services provided by a Designated Trauma Services member for clients who require major trauma services with an injury severity score of 9 or greater**. Do not use this modifier when billing for laboratory services.**

LT/RT:

Modifier used when the procedure is not designated bilateral or you have performed the procedure only on the left or right side of the body.

Anesthesia Modifiers

AA Anesthesia services personally furnished by an anesthesiologist. This includes services provided by faculty anesthesiologists involving a physician-in-training (resident). Reimbursement is 100 percent of the allowed amount. Modifier AA cannot be billed in combination with QX.

When supervising, the physician should use one of the modifiers below. Reimbursement for these modifiers is 50 percent of the allowed amount. Modifier QX should be billed by the Certified Registered Nurse Anesthetist (CRNA).

AD Medical supervision by a physician for more than four concurrent anesthesia services.

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

QS Monitored anesthesia services. **This modifier is not covered by MAA**.

To bill for monitored anesthesia care services, the following applies:

If the physician personally performs the case, modifier AA should be used and reimbursement is 100 percent of the allowed amount.

If the physician directs four or fewer concurrent cases and monitored care represents two or more of the case modifiers, modifier QK should be used and reimbursement is 50 percent of the allowed amount.

QX Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a physician should be used when under supervision of a physician. Reimbursement is 50 percent of the allowed amount. This modifier is payable in combination with Modifiers AD, or QK which is used by the supervising anesthesiologist. Modifier QX cannot be billed in combination with AA.

QY Certified registered nurse anesthetist (CRNA) and anesthesiologist are involved in a single procedure and the physician is performing the medical direction. The physician should use modifier QY and the medically directed CRNA should use modifier QX. The anesthesiologist and CRNA will each receive 50 percent of the allowance that would have been paid had the service been provided by the anesthesiologist or CRNA alone.

QZ CRNA service: Without medical direction by a physician should be used when practicing independently. Reimbursement is 100 percent of the allowed amount. This modifier cannot be billed in combination with any other modifier.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note:	If MAA has recouped a managed care plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  ✓ DSHS certification of a client for a retroactive[2] period; or
  ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the timeperiod listed above.

- The timeperiods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

Primary Care Case Management (PCCM) clients?

Clients who obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM. Bill MAA with the PCCM's provider number in the referring provider field.

Note: Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.

What general records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.**

See MAA's program specific billing instructions for information that may be necessary to keep in addition to those general records listed above.

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page R.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (younger than 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

When billing Medicare:

- Indicate *Medicaid* and include the patient identification code (PIC) on the claim form as shown on the client's DSHS Medical ID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing. (See page A.3 for address.)
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

NOTE:

- ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 30 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

NOTE:

- ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider must <u>accept</u> assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their DSHS Medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **neither Medicare or Medicaid** cover the service, MAA will not reimburse the service.

How to Complete the HCFA-1500 Claim Form

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens (use black ink for the circled "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink ir not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions for Completion

1a. **Insured's I.D. NO.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's DSHS Medical ID card. The PIC consists of the clients:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB Baby on Parent's PIC.

NOTE: The client's DSHS Medical ID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC, and enter indicator **B** in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.*

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number Of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PPCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2001 = 100401).

24B. **Place of Service**: Required. These are the only appropriate place of service codes:

Code	To Be Used For
1	Inpatient hospital
2	Outpatient hospital
3	Office
4	Client's residence
5	Emergency room
6	Ambulatory Surgery Center
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Congregate Care/Other

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

EPSDT billings: When applicable. Screening examination procedure codes **must** be followed by one of the following modifiers:

NR Indicates *No Referral*; well child
YR Indicates *Yes, Referred*; a condition exists which needs diagnosis or treatment

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

Healthy Kids/EPSDT: When applicable. When EPSDT indicator *YR* is used in Box 24D. (the *modifier* field), enter the ICD-9-CM diagnosis code indicating the problem found during screening. If indicator *NR* is used, you ***must*** enter either "V96.0" or "V20.2."

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24H. **EPSDT Family Plan**: When billing the department for one of the EPSDT screening procedure codes, enter an **X** in this field.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered:** When required, put the name of the facility where services were performed.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, *Address*, and *Phone #* on all claim forms.

P.I.N.:
This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.